CONFERENCE - 2008

NATIONAL COMMUNITY HEALTH NURSING CONFERENCE 2008

On "Nursing Leadership in Community Health"

September 18 - 20, 2008

Venue : **Scudder Auditorium, Christian Medical College, Vellore**

Organised By

Department of Community Health Nursing
College of Nursing
Christian Medical College, Vellore - 632004.

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NATIONAL COMMUNITY HEALTH NURSING CONFERENCE

on

NURSING LEADERSHIP IN COMMUNITY HEALTH

September 18TH - 20TH, 2008

Venue

Scudder Auditorium
Christian Medical College, Vellore

Organised by

Department of Community Health Nursing
College of Nursing
Christian Medical College, Vellore - 632 004,
Tamilnadu

Dr. CHELLARANI VIJAYAKUMAR,
Professor & Head
Community Health Nursing Department
Chirperson, Conference Convenors Committee &
Editor, Souvenir Committee.

MESSAGE

CONFERENCE CHAIRPERSON'S REMARKS

It is with heartfelt thanks to God, I write this piece for the conference souvenir. The last National Public Health Conference was conducted in 1981 by the Late Dr.Mrs.Kasturi Sundar Rao for TNAI in the RUHSA Department of CMC Hospital. We felt the strong need to share and update our expertise in Community Health Nursing. That is how this conference took shape.

Between 1981 and now, a lot of changes have taken place in the health scenario of our country. There are better technologies which have come to play a part in nursing education and practice. In recent times, many nursing schools and colleges have been opened to keep in line with India's growing health care system. The nursing curricula of all programs have given an important place for community health with reference to theory and clinical content. However, in the peripheral programmes of the country, we have not seen many changes in the category of health personnel assigned to meet the needs of communities both in urban and rural areas. On the whole, the health status of the general population has improved in the past years.

There are articles in this souvenir which touch on the pioneers in this field and the development of community health nursing within this institution. The forerunner of these programmes in CMC is our founder, Dr.Ida.S.Scudder, who reflected her concern in her numerous home visits and roadside clinics. I have had the privilege of working with some of the pioneers like Dr.Miss.Pauline.E.King, Mrs.Achyamma John, Dr.Mrs.Kasturi Sundar Rao and Dr.V.Benjamin. CMC Hospital has been committed to community health work and has demonstrated it in the different community health pro-

grammes such as RUHSA, CHAD, CQNCH and Urban programmes which cater to a population of 3,00,000. The administration has been very supportive in our initiation of CONCH programme.

It has been an experience of sorts that has had its ups and downs but we have come through. The purpose of organizing this conference is to bring together community health nurses from all over the country to share their views on leadership roles in the health care delivery system. My sincere thanks go out to Dr.Suranjan Bhattacharji, Director and Mrs. Bharathy Jacob, Dean, College of Nursing. I owe my thanks to my colleagues, Mrs.Rosaline Jayakaran, Mrs.Rajeshwari Siva, Mrs.Vathsala Sadan, Mrs.Greeda Alexander, Mrs. Shandrila Immanuel and the Faculty of College of Nursing for their continued support through the various committees. I am indebted to the Principal, Dr.Anand Job, Christian Medical College for permitting us to use the Scudder Auditorium for holding the conference. I commend the continued support of Souvenir Committee members, Mrs.Beulah Premkumar, Mrs.Ruma Nayak, Mrs.Grace Moses and Mr. Julius J. for their work in publishing this souvenir. I appreciate the clerical help given by Mrs. Ruby Winser and Mrs. Vijayalakshmi.

We are thankful to all the Government officials for graciously accepting our invitation to take part in the inauguration and valedictory functions and sending their felicitations. We are thankful to Mrs. Sundari Edwin, Nursing Superintendent, CMC Hospital, Snehadeepam and RUHSA Department for providing accommodation for the delegates.

The current registrations revealed that majority of the delegates are BSc, MSc graduates and MSc students. We made it a point to bring nurses working in community health programmes. We hope that those who attend this conference would be inspired to take up leadership roles and become trendsetters at their institutions in the field of Community Health Nursing.

I believe that we are at crossroads and it is time to take a stand as to how we can serve the needs of our country. It will definitely be a good experience and a defining moment as we meet our peers and share our thoughts and dreams that will shape the future of our nation.

Dr. Chellarani Vijayakumar.
Chairperson, Conference Organizing Committee
& Chairperson, Souvenir Committee.

सत्यमेव जयते

अर्चना दत्ता (मुखोपाध्याय)
विशेष कार्याधिकारी (जन सम्पर्क)
Archana Datta (Mukhopadhyay)
Officer on Special Duty (Public Relations)

राष्ट्रपति सचिवालय,
राष्ट्रपति भवन,
नई दिल्ली - 110004
President's Secretariat,
Rashtrapati Bhavan,
New Delhi - 110004

MESSAGE

The President of India, Smt. Pratibha Devisingh Patil, is happy to know that the Community Health Nursing Department of the College of Nursing of the Christian Medical College, Vellore is organising a National Community Health Nursing Conference on the theme "Nursing Leadership in Community Health" from September 18-20, 2008.

The President extends her warm greetings and felicitations to the organisers and the participants and wishes the Conference every success.

A. Datta

Officer on Special Duty (PR)

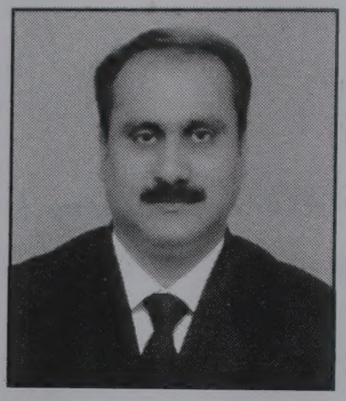
சுகாதாரம் மற்றும் குடும்பநலத் துறை அமைச்சர்
இந்திய அரசு
நிர்மான் பவன், புதுதில்லி - 110108

MINISTER OF HEALTH & FAMILY WELFARE
Government of India, Nirman Bhawan,
New Delhi - 110 108

2 Sep. 2008

மருத்துவர் அன்புமணி இராமதாசு
Dr. ANBUMANI RAMADOSS

MESSAGE



I am happy to learn that the Community Health Nursing Department of the Christian Medical College, Vellore (TN) is organizing a National Community Health Nursing Conference on the theme 'Nursing Leadership in Community Health' from 18th to 20th September 2008 at Vellore (Tamil Nadu) and that a Souvenir is being released on the occasion.

Nursing is an Integral part of the health system and nurses are crucial for safe motherhood, hygiene and overall health care. They have a role to play in treatment and care. Nursing forms an indispensable part of curative treatment also. Realising their contribution, the Centre has decided to create Centre of Excellence for Nursing in the various parts of the country.

It is very heartening to know that people trained in the Community Health Nursing Department (Christian Medical College), Vellore (TN) for such a noble profession, are becoming very competitive and are serving across the globe bringing a good name for the country.

I wish the Community Health Nursing Department of the Christian Medical College Vellore (TN), the Conference and the Souvenir a grand success and hope that these modern day Nightingales will bring material change in the cure and rehabilitation to patients through continued dedicated and selfless service.

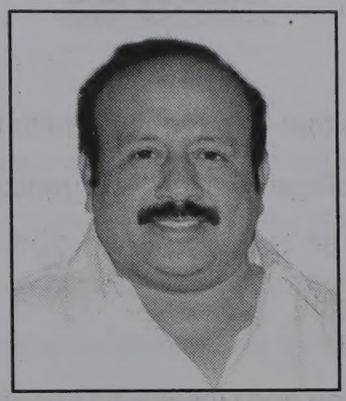
Dr. ANBUMANI RAMADOSS

M.R.K. PANNEERSELVAM
MINISTER FOR HEALTH

SECRETARIAT
CHENNAI - 600 009.

Date : 10-9-2008

MESSAGE



I am glad to know that the Community Health Nursing Department, College of Nursing, Christian Medical College, Vellore is organizing a National Community Health Nursing Conference from 18th to 20th. September 2008 on "Nursing Leadership in Community Health". The theme of the conference is aptly chosen. The deliberation at the Conference will provide on excellent opportunity for the Community Health nurses to collectively share their knowledge and expertise, and focus on nursing leadership in planning, implementing, and evaluating the health care programmes.

On this happy occasion, I extend my greetings and best wishes for the organizers and the participants of the conference.

10/9/08

(M.R.K. PANNEERSELVAM)

Thiru. **V.K. SUBBURAJ**, I.A.S.,
Principal Secretary to Government

Health and Family Welfare Department
Secretariat, Chennai - 600 009.
Off ☎ : 2567 1875
Fax : 2567 1253
E-mail : hfsec@tn.gov.in

Dated : 04-09-2008

MESSAGE

I am delighted to know that Community Health Nursing Department, College of Nursing, Christian Medical College, Vellore is organizing National Community Health Nursing Conference from 18th September to 20th September 2008 on Nursing Leadership in Community Health.

Christian Medical College and Hospital has been providing commendable health services in the State and in the country since its inception and Nursing has been always an integral part of health care.

I wish this Conference to bring Community Health Nurses from different parts of the Country together and deliberate on Challenges ahead of them to meet the health demands of the country in various leadership positions.

I wish the organizers, the very best for the success of the Conference.

5/9/2008

(V.K. SUBBURAJ)

P.W.C. DAVIDAR, I.A.S.,
Special Secretary to Government
Health & Family Welfare Dept.,
&
Project Director.

Tamil Nadu Health Systems Project
7th Floor, DMS Building,
Chennai - 600 006.
Tel. Off : (91-44) 24345990
Fax : (91-44) 2434 5997
Email : mail@tnhsp.net

Dated : 08-09-2008

MESSAGE

It gives me great pleasure to extend my best wishes in the conduct of the Community Health Nursing Conference – 2008. Community Health Nursing is the key to all the major health issues that our country has to contend with. The trend towards non-communicable diseases is evident and tackling this at the community level is of paramount importance. As you meet to discuss and discover best practices in different parts of our country, I sincerely hope that tangible lessons and ways of tackling the current health demands will bring up valuable lessons in leadership that can be models in the field of community health nursing. Wishing you the very best in the conduct of the Conference.

Yours Sincerely,

(P.W.C. DAVIDAR)

Dr.S.Elango, MBBS., MD.,DPH.,DIH.,
Director of Public Health & Preventive Medicine
359, Annasalai, Chennai-6.

Date : 14.09.2008

MESSAGE

I am happy to note that Department of Community Health Nursing, College of nursing Christian Medical College, Vellore- 632 004 is organizing a National Community Health Nursing conference on 18th to 20th September 2008 at Vellore.

The theme of the conference Nursing leadership in Community Health is a thought provoking title and it is an essential theme of the day.

I wish the Conference a grand success.

Dr. S. ELANGO

Selvi. **APOORVA**, I.A.S.,
Special Secretary to Government

Health and Family Welfare Department
Secretariat, Chennai - 600 009.
Tele fax : 044 - 2567 5459

Dated : 14-08-2008

MESSAGE

I am happy to learn that Community Health Nursing Department, College of Nursing, Christian Medical College, Vellore is organizing a National Community Health Nursing Conference on "Nursing Leadership in Community Health" from 18th - 20th September 2008 at Vellore, Tamil Nadu.

Community Health Nurse work outside of the traditional hospital setting focusing primarily on developing basic health care systems that can be easily accessed by populations who currently have little or no access to basic preventive care. They also work to integrate health care systems, effect policy changes and establish equality in provision of health care. Hence a community health nurse must be a health promoter, disease and illness manager, strategic planner, policy developer and in a nut shell a Health leader.

I am sure the deliberations at the conference will create future leader in health care and develop a continuously improving and self regulatory health care delivery system.

I wish the conference all success.

Sd/-
APOORVA

The Tamil Nadu Dr. M.G.R. Medical University

CHENNAI

Prof. Dr. K. MEER MUSTAFA HUSSAIN,
M.D., D.C.H., Ph.D., F.R.C.P. (Glasgow)
Vice-Chancellor

No. 69, Anna Salai, Guindy,
Chennai - 600 032.
Phone : (O) 2235 3595
(R) 2642 4561
Fax : 91-44-2235 3698
E-mail : doc_meer@yahoo.com

MESSAGE

8th September 2008

It gives me an immense pleasure to offer a Message of Felicitation on the occasion of the National Community Health Nursing Conference on "Nursing Leadership in Community Health" from 18th to 20th Sep. 2008. under the auspices of Community Health Nursing Department, College of Nursing, Christian Medical College, Vellore.

I firmly believe that this Conference would dwell at length on the promotion of Nursing Leadership in Community Health and enrich the delegates with its outcome.

I wish the conference of all success.

(Prof. Dr. K. MEER MUSTAFA HUSSAIN)

THE TRAINED NURSES' ASSOCIATION OF INDIA

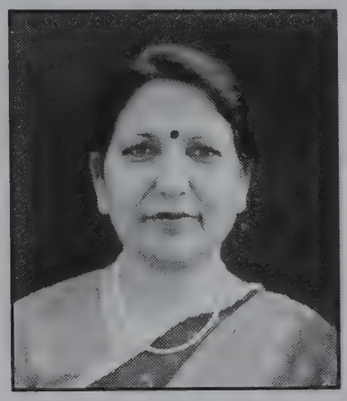
FOUNDED IN 1908

Registered under the Society Act XXI of 1860 in 1917, Registration No. 199 Incorporated in it
Students Nurses' Association, Health Visitors' League and Midwives and
Auxillary Nurse-Midwives' Association
Affiliated to Commonwealth Nurses' Federation
L-17, Florence Nighingale Lane, Green Park, New Delhi - 110 016. INDIA
Tel. : +91-11-26566665, 26966873 * Telefax : +91-11-26858304
E-mail : tnai@ndf.vsnl.net.in, tnai_2003@yahoo.com * Website : www.tnaionline.org

TNAI CELEBRATING 100 YEARS OF CARING

1908 - 2008

MESSAGE



On behalf of the Trained Nurses Association of India and the entire nursing fraternity of India, I would like to convey my heartfelt greetings and blessings to the faculty, students and staff of the Community Health Nursing Department of College of Nursing, CMC Vellore for organizing a National Community Health Nursing Conference on **"Nursing Leadership in Community Health", the theme for the conference is aptly chosen.**

Today Indian Nurses all over the world celebrate Centenary of their Association and CMC Vellore almost there to celebrate the Centenary of Nursing Education, which was started in 1909. CMC Vellore is one of the pioneer institute to start B.Sc nursing programme in the country. We applaud your efforts for adding another feather in the **First National Community Health Nursing Conference.** There are reasons for us to stand tall and be proud. Indian Nurses, wherever they are, whichever post they are in, doing their country proud by their exemplary services, determination and devotion. We are proud of you all, those who are serving the community with the same compassion and commitment as their counterparts in hospital settings, because nursing is carrying and 'CARING' is universal.

My honest appreciations are for the Editorial Board for releasing the Conference Souvenir. May the auspicious occasion be a source of blessing for all those who are attending the Conference.

Wishing you all a grand success to those who are associated with the First National Community Health Nursing Conference.

God Bless.

Mrs. **SHEILA SEDA**
Secretary - General

DHARMENDRA PRATAP YADAV I.A.S.,
Collector
Vellore District

Telephone : 0416 - 2252345 (O)
0416 - 2222000 (R)
Fax : 0416 - 2253034 (O)
0416 - 2228029 (R)
Web : http://www.vellore.tn.nic.in
e-mail : collector@vlr.tn.nic.in

Date : 01-09-2008

MESSAGE

It gives me great pleasure to know that the Community Health Nursing Department of College of Nursing, Christian Medical College, Vellore is organising a National Conference on "Nursing Leadership in Community Health" during 18th to 20th September 2008.

I wish the College of Nursing, Christian Medical College, Vellore all the best in its endeavor to provide quality nursing education to all its nursing students.

DISTRICT COLLECTOR

Dr. S. RAJASEKARAN, MBBS., DPH (Calcutta)
Deputy Director of Health Services
Vellore District.

MESSAGE

Vellore Health Unit District which consists of 10 Blocks with 35 PHCs has been declared as a role model for Tamilnadu State for PHC deliveries, Immunisation and the implementation of NRHM goals. Vellore HUD is the first in the country to conduct Caesarean Operations (LSCS), establish Blood storage facilities at Government PHCs under the guidance of Dr. S. Elango, DPH & PM and Thiru D.P. Yadav, IAS, District Collector, Vellore.

Dr. S. Rajasekaran, on my personal and on behalf of my health team, I wish this conference a success.

15/9/08

Dr. S. RAJASEKARAN

All communications to be addressed to the 'Registrar' and not by name

GOLDEN JUBILEE
1926-76

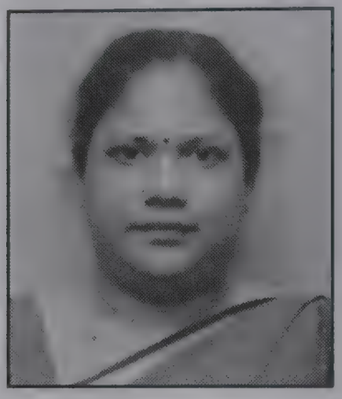
Telefax : 91-44-24620547
Jayaprakash Narayanan Maligai,
140, Santhome High Road,
(Near Santhome Church)
Mylapore, Chennai - 600 004.
E-mail : info@tamilnadunursingcouncil.com
Web www.tamilnadunursingcouncil.com
Tel : 91-44-24934792

TAMIL NADU NURSES AND MIDWIVES COUNCIL, CHENNAI.

(Constituted Under Tamil Nadu Act III of 1926)

MESSAGE

Date : 29-08-08



With immense pleasure I write this abridged message.

I take this opportunity to extend my hearty felicitations to Community Health Nursing Department, Vellore in organizing the National Community Health Nursing Conference on "National Leadership in Community Health" from 18th to 20th September 2008 and release of conference souvenir connected therewith.

Christian Medical College, Vellore, is well known for its hallmark in India and at global level. The dedicated sincere services with multifarious educational facilities to the students with appreciable academic environments and excellent academic climate in the field of health education by the Mission are "labour of love".

It is needless to say that Nursing personnels must be exposed to community setting which is well selected and well organized. The conference at National level will surely have fruitful results and nursing professionals and community will have acquaintance with the current advancement and career guidance in our country and abroad.

Health is an inalienate right of every human being. Nursing is a noble profession and in particular community health is vital at this critical juncture. There is no limitation for nursing learning and implementation and the conference connected now will enable the concerned to aquire knowledge, with excellence, new discoveries and innovations, in addition to their learning through internet base access to websites, interactive multimedia, computer assisted learning in this present era. This will enable the professionals to make judicious decisions in providing comprehensive quality care.

I am delighted to felicitate the Mission with festoon of flowers for the strenuous efforts in organizing the valuable National Conference and publication of Souvenir.

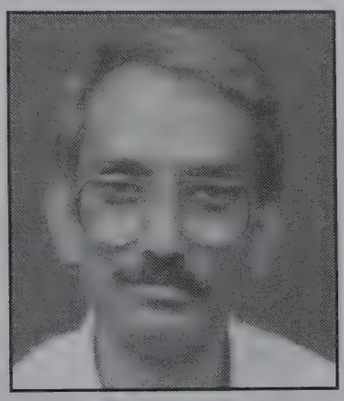
My prayers and best wishes for the grand successful release of the Conference Souvenir.

Ms. JOSEPHINE LITTLE FLOWER
Registrar
Tamilnadu Nurses and Midwives Council
Chennai - 600 004.

Christian Medical College, Vellore, India.
Directorate

05-09-2008

MESSAGE



I am happy to know that the Community Health Nursing Department of College of Nursing is organizing a National Community Health Nursing Conference on 'Nursing Leadership in Community Health' from 18 to 20 September 2008.

The achievements of the College of Nursing in the field of Community Health have been impressive and inspiring. We are proud of your hard work and commitment to excellence.

We thank God for His innumerable blessings on you and through your work on many, many people. On behalf of the institution I wish you all the very best and pray for God's blessings as you meet with other professionals during the conference and deliberate on how you can be ever more effective in the days ahead.

Suranjan Bhattacharji

SURANJAN BHATTACHAJI
Director

Ida Scudder Road, Vellore - 632 004. Tel : 0416 - 2282010 Director : Personal (Off) : 2232024
Fax : 0416 - 2232054, 2232035 Email : directorate@cmcvellore.ac.in

COLLEGE OF NURSING
CHRISTIAN MEDICAL COLLEGE,

Ida Scudder Road, Vellore - 632 004. S.India

Who Collaborating Centre
For Nursing and
Midwifery Development

Dean : **Mrs. Bharathy Jacob,** B.Sc.N., R.N., R.M., M.Sc.N.,
Deputy Dean : **Mrs. Rosaline Jayakaran,** B.Sc.N., R.N., R.M., M.Sc.N.,
Addl. Deputy Dean : **Mrs. Christy Simpson,** B.Sc.N., R.N., R.M., M.Sc.N.,
Addl. Deputy Dean : **Mrs. Sheeba Susan Chandy,** B.Sc.N., R.N., R.M., M.Sc.N.,
Addl. Deputy Dean : **Mrs. Florence Segaran,** B.Sc.N., R.N., R.M., M.Sc.N.,

MESSAGE

I would like to congratulate Dr.Chellarani Vijayakumar, Head of Community Health Nursing department for having taken the initiative to host a National Community Health Nursing conference in Christian Medical College, Vellore.

College of Nursing at C.M.C.has pioneered the development of Community Health Nursing in the country. In 1947 Community Health Nursing was introduced as a subject first in the B.Sc.Nursing curriculum. The department has also started a nurse managed programme known as CONCH programme in 1987, which renders primary care to the community for approximately 20 villages. With this rich history, it is most appropriate for the department to organize a conference on "Nursing Leadership in Community Health".

I am confident that this conference will enable nurses from different parts of the country to share their knowledge and to equip themselves as good leaders in community health nursing practice.

I extend my best wishes to the organizers and the participants and pray for God's blessings on the conference.

Bharathy Jacob

Mrs. BHARATHY JACOB
Dean, College of Nursing

Te : 91-416-2282068 ; 91-416-2282021 Fax : 91-416-2223362
Email : deancon@cmcvellore.ac.in

OFFICE OF THE NURSING SUPERINTENDENT
CHRISTIAN MEDICAL COLLEGE
Ida Scudder Road, Vellore - 632 004.
Tamil Nadu, India.

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E-mail : nso@cmcvellore.ac.in

Mrs. Sundari Edwin, B.Sc.N., RN., R.M., M.Sc.N.,
Nursing Superintendent
Mrs. Leah Macaden, B.Sc.N., RN., R.M., M.Sc.N.,
Dy. Nursing Superintendent
Mrs. Jasmin Anand, B.Sc.N., RN., R.M., M.Sc.N.,
Addl. Dy. Nursing Superintendent
Mrs. Alice Sony, B.Sc.N., RN., R.M., M.Sc.N.,
Addl. Dy. Nursing Superintendent

Ref :
Date : 09-09-2008

MESSAGE

I am very delighted to extend my warm greetings to the Department of Community Health for organizing the National Conference on Leadership in Community Health Nursing. I congratulate you for releasing the souvenir on this occasion.

I commend you for your nobility in using your knowledge, skills and experience for providing to the needs of the children, adult and elderly alike. I appreciate you for the unique leadership you offer and your passionate call to share it with many during this conference.

May God grant you great success and may it remain a glorious memory to all.

With best wishes,

S. Edwin

Mrs. SUNDARI EDWIN
Nursing Superintendent.

CHRISTIAN MEDICAL COLLEGE
VELLORE - 632 004 INDIA

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2284293
Telegram : MEDCOL
Telefax : 0416 - 2262788 / 2262268
2232035
E-mail : princi@cmcvellore.ac.in

Ref :

Date : .....

MESSAGE

I am delighted to note that the National Community Health Nursing Conference is being organized by the Community Health Nursing Department of CMC from 18th to 20th September, 2008 at Scudder Auditorium. The Faculty and Staff of this department have been providing yeoman service for the poor and marginalized and is an important arm of CMC towards following our motto "Not to be ministered unto but to minister". I am sure that this conference will provide an opportunity to draw inspiration from one another and reaffirm their steadfastness in the field of Community Health Nursing.

Wishing the conference all success.

Dr. ANAND JOB
Principal

COMMUNITY HEALTH DEPARTMENT

CHRISTIAN MEDICAL COLLEGE

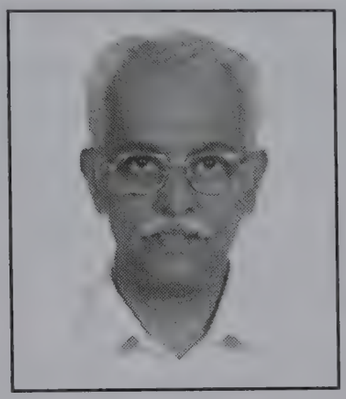
VELLORE - 632 002.

INDIA

WHO COLLABORATING CENTRE
FOR
COMMUNITY BASED HEALTH
PROFESSIONS EDUCATION

September 6, 2008

MESSAGE



I am happy to note that the Community Health Nursing Department, College of Nursing of CMC Vellore is organizing a conference on "Nursing Leadership in Community Health" from 18th to 20th September 2008.

Even though the country is said to be developing rapidly, the true reality is that the proportion of disadvantaged and marginalized is truly increasing. The Government of India has recognized the need for greater inputs in the field of public health. The NRHM initiative is indeed a good example for this. It is also true that leadership in Community Health Nursing is lacking when you consider the size of Indian Population. The Primary Health Care concept need to be rejuvenated and health care need to be converted into a people's movement. Community Health Nursing can play a vital role in this direction.

I wish the conference all success.

Dr. JAYAPRAKASH MULIYIL, MD, MPH, Dr.PH
Professor and Head

Telephone : 91-416-2284207 / 2222102 / 5200000 Extn. 4207
Fax : Dept -91-416-2262268, College -91-416-2262788 / 91-416-2232035
Email : chad@cmcvellore.ac.in

Miss Beryl A.Devaneson
Retd. Professor and Principal
College of Nursing,
Madras Medical College & Bishop's College of Nursing,
Dharapuram. 'PATMOS', Church Hill
Coonoor - 643 101.

MESSAGE

I am delighted to learn about the National Community Health Nursing Conference organized by the Community Health Nursing Department of College of Nursing, CMC, Vellore. I had the privilege of having close relationship with Dr. Miss Pauline E.King, Mrs.Achyamma John and Dr.Kasturi Sundar Rao. I sincerely hope that during this conference the nurses will discuss on various issues related to the Health Care in the country and come with relevant decisions about involvement of Community Health Nurses. These decisions will help to enhance their competencies to improve quality of health services to individuals, families and communities in the coming future.

My best wishes for the organizers of the conference.

Miss BERYL A.DEVANESON

Mrs. **ACHYAMMA JOHN**
Former Dean & Head of Community Health Nursing Dept.
College of Nursing
CMC, Vellore-2.

MESSAGE

I am glad to know that the Community Health Nursing Department of College of Nursing, Christian Medical College, Vellore is organizing a National Community Health Nursing Conference. The noble service that is being rendered by the Community Health Nurses is widely appreciated. I do hope that this conference will help Community Health Nurses from various parts of the country to have a unique opportunity of interaction ; will be equipped in focusing public attention on some of the coutnry's health problems and possible lines of solution through health promotion and health education.

My best wishes for the success of the Conference.

Achyamma John

Mrs. **ACHYAMMA JOHN**

Mrs. **VIOLET JAYACHANDRAN**
Retd. Professor of Nursing & Former Deputy Dean
College of Nursing
CMC, Vellore.

MESSAGE

My congratulations to you and your department for organizing the National Community Health Nursing Conference at Vellore. The programme and objectives of the conference are very impressive and will no doubt provide the participants a forum to project new modalities for delivery of the best possible health care to the millions in our country. My thoughts go back to the pioneers in Community Health Nursing at the College of Nursing C.M.C. and their untiring efforts in building the curriculum and providing suitable practical experience to the students in Rural and Urban settings. The successive generations in the department have risen up to the new challenges and introduced innovative programmes like the CONCH scheme, which is commendable and widely appreciated.

May God, the Almighty bless all your efforts in giving leadership for Community Health Nursing and initiating a National level conference.

My best wishes and prayers for a successful deliberation at the conference.

Mrs. VIOLET JAYACHANDRAN

Miss **ANNA JACOB**
Former Nursing Superintendent
C.M.C. Hospital, Vellore.

MESSAGE

I am delighted to know that the Community Health Nursing Department of College of Nursing, Christian Medical College, Vellore is organizing a National Community Health Nursing Conference.

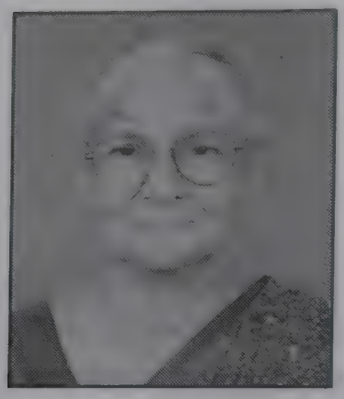
I hope that this conference would pave way for a revolution in the country and enrich the Community Health Nurses personally in having the care and concern to serve the people who are in poverty and ignorance, spread the message of health promotion and bring light in their lives.

I have great pleasure in wishing the organizers and the participants for a successful and meaningful conference for the Glory of God.

Miss **ANNA JACOB**

Mrs. **SARAMMA GEORGE**
Retd. Professor & Former Dean
College of Nursing
CMC Vellore.

MESSAGE



I am happy to congratulate the Community Health Nursing Department in organizing a National conference on "Nursing leadership in Community Health". You have shown leadership in the Community Health Nursing field in our country.

It is commendable that a conference is being organized after 27 years as the earlier conference was held in 1981. I thank the organizers for asking me to express my thoughts at this occasion. The Community Health Nursing department has demonstrated that there is a need for nursing leadership in our country, especially in our teaching institutions.

I remember late Miss. K.A. Norris who was instrumental in starting a Public Health Nursing field in 1947 to enable the nursing students to learn what nursing can be in their homes both in the Urban and Rural setup. I had close contact with the department in early 1950 as I worked in the department for two years as a junior supervisor. I have seen its development and appreciated the efforts of the pioneers in Community Health Nursing. The growth and development of the department was steady as the College of Nursing also grew gradually.

In the late 1980 the acute need for better field teaching and experience became necessary for our students that in turn necessiated the expansion of both urban and rural fields. It was felt that more participation in collaboration with government agencies will help in better education and field experience for the students and better service for the community. I was fortunate to serve as the Dean of the College of Nursing during this period. It is fulfilling to remember the contribution of Dr.Miss. Pauline E.King and Mrs. A John who pioneered the Community Health Nursing Department through out her service in CMC.

I also remember with gratitude late Dr. Kasturi Sundar Rao and Mrs. Dorothy Kaushik and Dr. Chellarani Vijayakumar who showed their hard work and leadership qualities during this period which enabled us to start the community out reach programme namely the College of Nursing Community Health Programme (CONCH) in the Ussoor and Arcot blocks for community health clinical experience for the nursing students in 1987. This has also showed us a fitting platform to demonstrate the skills of the community health nursing in providing family centered care in collaboration with the government infrastructure.

I am thankful to Dr. B.M. Pulimood, the Director for giving us the freedom to negotiate with the Public Health Department of Government of Tamil Nadu. It is apt to express our gratitude to the government officials for their kind and considerate response in making the CONCH programme a reality. I am thankful to God, the CMC administration and the nursing leaders in the Community Health Nursing field for rendering the needed help and co-operation in starting the above programme.

The leaders is the community Health Nursing field has further developed the activities and brought the Conch program to what it is today which is contributing mightily to the family centered care demonstrated by the College of Nursing which includes the Community Health Nursing Department.

I pray to God and add my best wishes for the National Community Health Nursing Conference to be held in Sept. 18th to 20th 2008.

Souvenir Committee

Top row - left to right : Mrs. Vathsala Sadan, Mrs. Greeda Alexander, Mrs. Ruma Nayak, Mrs. Shandrilla Immanuel, Mrs. Grace Moses
Bottom row - left to right : Mrs. Beulah Premkumar, Dr.Chellarani Vijayakumar, Mrs. Bharathy Jacob, Mrs. Rosaline Jayakaran, Mrs. Rajeshwari Siva

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Convenors of Conference Committees

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CONFERENCE PROGRAMME

THURSDAY - SEPTEMBER 18, 2008

1-00 p.m. - 2-00 p.m. : Registration

2-00 p.m. - 3-15 p.m. : **PRE - CONFERENCE WORKSHOP**

Health Economics

Dr. K.R. JOHN, M.D., Dip NB, DCH
Professor - Community Health Department, C.M.C., Vellore

3-15 p.m. - 3-30 p.m. : Refreshments

3-30 p.m. - 4-45 p.m. : ***Scientific Writing***

Dr. G. GAGANDEEP KANG, M.D., (Micro) MRC (Path), Ph.D
Addl. Vice Principal, C.M.C., Vellore.

Presider :

Mrs. SHIRLEY DAVID, M.Sc.(N)
Professor & Head, Department of Fundamentals of Nursing
College of Nursing, C.M.C., Vellore

5-00 p.m. - 6-30 p.m. : **Inauguration**

Chief Guest :

Mr. P.W.C. DAVIDAR, IAS
Special Secretary to Govt. of Tamilnadu
Health & Family Welfare Department, Chennai

Key Note Address :

Dr. S. ELANGO, M.D., DPH., DNH
Director of Public Health & Preventive Medicine, Govt. of Tamil Nadu

Special Guest :

Ms. B.A. DEVANESON, DPH (N), M.Sc. (USA)
Former Principal, MMC College of Nursing, Chennai &
Bishop's College of Nursing, Dharapuram

6-30 p.m. : Tea

FRIDAY - SEPTEMBER 19, 2008

7-30 a.m. - 8-30 a.m. : Registration

8-30 a.m. - 9-30 a.m. : **SCIENTIFIC SESSION I**

Evidence Based Health Care

Dr. ABRAHAM JOSEPH, DCH, MD, (Com. Med), M.S.Epid. (USA)
Former Head of Community Health Department, CMC, Vellore &
Former Director, SIHR&L Centre, Karigiri

Evidence Based Nursing Practice

Dr. MARY S. IMMANUEL, M.Sc.(N), Ed.D(USA)
Former Dean, College of Nursing, C.M.C., Vellore
Director of Nursing, Tiruvalla Medical Mission, Kerala

Presider .

Mrs. ROSALINE JAYAKARAN, M.Sc.(N)
Professor, Community Health Nursing, C.M.C., Vellore

9-30 a.m. - 10-00 a.m. : Refreshments

10-00 a.m. - 11-00 a.m. : **SCIENTIFIC SESSION II**

Research in Community Health - Current Scenario

Dr. P.S.S. SUNDAR RAO, M.A, MPH, Dr. PH, FSMS, FSS
Former Head of Biostatistics Department, C.M.C., Vellore &
Research Consultant, The Leprosy Mission, New Delhi

Presider :

Dr. JAYARANI PREMKUMAR, M.Sc.(N) Ph.D
Professor & Head, Medical Nursing Department
College of Nursing, C.M.C., Vellore

11-00 a.m. - 12-00 N : **CONCURRENT SESSIONS I**

12-00 N - 1-00 p.m. : **POSTER PRESENTATIONS**

1-00 p.m. - 200 p.m. : **LUNCH**

2-00 p.m. - 3-00 p.m. : **PANEL DISCUSSION I**

Theme : ***Innovative Models in Community Health Nursing***

Innovation : Karnataka Model

Dr. T.M.KRISHNAVENI, M.Sc.(N), Ph.D
Former Asst. Director of Public Health Nursing,
Directorate of Health and Family Welfare Services
Bangalore

Community Oriented Nursing Education and Practice :
An Innovative & Collaborative Model

Mrs. VATHSALA SADAN, M.Sc.(N)
Professor, Community Health Nursing, College of Nursing
C.M.C., Vellore

Innovations in Community Health Nursing

Dr. REKHA OGALE, M.Sc.(N), Ph.D
Principal, Sinhgad College of Nursing, Pune

Community Nurse Practitioner Model

Dr. JEYASEELAN, M.DEVADASON, M.Sc.(N), Ph.D.,
Dean, Annai J.K.K.S.A. College of Nursing
Komarapalayam

Moderator :

Dr. Sr. MARY LUCITA, M.Sc.(N), Ph.D
Principal, Institute of Nursing Education
Mahatma Gandhi University, Kottayam, Kerala

3-00 p.m. - 3-15 p.m. : Refreshments

3-15 p.m. - 4-15 p.m. : **PANEL DISCUSSION II**

Theme : ***Community Partnership***

PACHOD Project

Dr. ASHOK DAYAL CHAND, MD (Paed)
DIrector, IHMP, Pune

CMAI, Community Health Programmes

Dr. SHOBA YOHAN
Consultant, Community Health Section, CMAI

Empowering persons living with stigmatizing conditions

Dr. GIFT NORMAN, MD
Head of Community Health Department, SIHR&L Centre, Karigiri

The Mitra Model

Mrs. SHIMY MATHEW, M.Sc.(N)
Tutor, School of Nursing, Christian Hospital, Bissamcuttack

Moderator :

Dr. JAYAPRAKASH MULIYIL, MD, MPH, Dr. P.H (Epid)
Head of Community Health Department
Former Principal, CMC, Vellore

4-15 p.m. - 5-15 p.m. : **CONCURRENT SESSION II**

6-00 p.m. - 7-30 p.m. : **CULTURAL PROGRAMME**

7-30 p.m. - 9-30 p.m. : CONFERENCE DINNER

SATURDAY - SEPTEMBER 20, 2008

8-00 a.m. - 9-00 a.m. : **SCIENTIFIC SESSION III**

Future Directions of Community Health Nursing Profession

Dr. CHELLARANI VIJAYAJKUMAR, M.Sc.(N), Dip.H.Edn., Ph.D
Professor & Head, Community Health Nursing Department
Former Dean, College of Nursing, C.M.C., Vellore

Presider :

Mrs. BEULAH PREMKUMAR, M.Sc.(N)
Prof. in Nursing College of Nursing, C.M.C., Vellore

9-00 a.m. - 10-00 a.m. : **PANEL DISCUSSION III**

Theme : ***Leadership in Community Health Nursing***

Education : **Dr. VIJAYALAKSHMI ETHIRAJ,** M.Sc.(N) Ph.D
Principal, College of Nursing, Annamalai University, Chidambaram

Practice : **Dr. REDDAMMA,** M.Sc.(N). Ph.D
Principal, Sree Vidyanikethan of Nursing, Tirupati.

Research : **Dr. PATLIA, MAYA E.** M.Sc.(N), Ph.D
Principal, PG College of Nursing, Bhilai.

Professional Development : **Dr. ROSALIND CONWAY,** M.Sc.(N), Ph.D
Chief of Nursing & Allied Services, Sree Valli Anantharamakrishnan
Institute of Child Health, Chennai

Moderator :

Dr. REBECCA SAMSON, M.Sc.(N), Ph.D
Principal, Padmashree College of Nursing, Bangalore

10-00 a.m. - 10-30 a.m. : Refreshments

10-30 a.m. - 11-30 a.m. : Open Forum

Dr. RAJKAMAL, S.POTDAR, M.Sc.(N), Ph.D
Principal, Bharati Vidyapeeth Deemed University
School of Nursing, Dhanakawadi, Pune

11-30 a.m. - 1-00 a.m. : **VALEDICTORY FUNCTION**

Chief Guest :

Miss. APOORVA, IAS
Special Secretary,
Ministry of Health & Family Welfare, Govt. of Tamil Nadu

Special Guests :

Dr. RAJASEKARAN, MBBS., DPH
Deputy Director of Health Services, Vellore Dt.

Ms. JOSEPHINE LITTLE FLOWER, M.Sc.(N)
Registrar, TN State Nurses' & Midwives' Council, Chennai

1-00 p.m. : Lunch

NATIONAL COMMUNITY HEALTH NURSING CONFERENCE - 2008

CONCURRENT SESSION - I

19th September 2008 - 11-00 am - 12-00 noon

Venue : Scudder Auditorium
Themes : Communicable Diseases
Chair : **Dr. Jaya Mohanraj**

Time	Topic	Name
11-11.15 am	Role of Nurse in Leprosy	Dr. Chellarani Vijayakumar
11.15-11.30 am	Enhancing the knowledge of ward Attendants regarding nosocomial infection	Ms. Radha Saini
11.30-11.45 am	Effectiveness of a structured teaching Programme among mothers on knowledge and practice of home care Management of children with tuberculosis in selected DOTS centres.	Mr. Venkatesh Murthy
11.45 am - 12.00 Noon	Effectiveness of Information, Education Communication package on knowledge and attitude on HIV/AIDS among college students.	Ms. C.D.Thilagam

19th September 2008 - 11-00 am - 12-00 noon

Venue : CHTC Auditorium
Themes : Non-Communicable Diseases
Chair : **Dr. A. Reddamma**

Time	Topic	Name
11.00-11.15 am	The Nurses sociological study of their problems and job satisfaction of nurses working in Govt. Hospital	Dr. Maya E. Patlia
11.15-11.30 am	Prevalence of obesity and the effectiveness of a structured interventional programme on the knowledge, attitude and practice of obese women in selected rural areas.	Mrs. Baby Saroja
11.30-11.45 am	Vellore-World Diabetes Foundation Rural Projects	Mrs. Ruth Daniel
11.45 am 12.00 Noon	RAKSHA CARES YOU - Palliative Care	Mrs. Janey Kemp

19th September 2008 - 11-00 am - 12-00 noon

Venue : MHC - Hall 1

Themes : Family Nurses Practitioner, Occupational Health Nursing and Community Mental Health Nursing

Chair : **Dr. Jeyaseelan M. Devadason**

Time	Topic	Name
11.00-11.15 am	Image of nursing and perception of independent nursing practice as expressed by Panchayat leaders	Mrs. Juliet Sylvia
11.15-11.30 am	Meta Analysis of studies on the role of family nurse practitioners in reaching the unreached.	Mrs.Rajeswari Siva
11.30-11.45 am	Byssinosis - Occupational Disease.	Mrs. Thanga Subbulakshmi
11.45-12.00 Noon	Psycho social stress and coping behaviors among prisoners	Ms. Amanpreet Kaur

19th September 2008 - 11-00 am - 12-00 noon

Venue : MHC - Hall II

Themes : Geriatic Care

Chair : **Dr. P.Mangala Gowri**

Time	Topic	Name
11.00-11.15 am	A study to determine the prevalence of depression among elderly population in selected area.	Ms. S.Margaret
11.15-11.30 am	Tailor made education to the elderly in prevention and management of specific health problems.	Prof. T.Nirmala
11.30-11.45 am	Quality of life in the elderly and effectiveness of geriatric social club.	Mrs. Shandrilla Immanuel
11.45-12.00 noon	Assessing Falls. Identifying causes of falls among elderly.	Dr. Prasanna Baby

NATIONAL COMMUNITY HEALTH NURSING CONFERENCE - 2008

CONCURRENT SESSION - II

19th September 2008 - 4-15 - 5-15 pm

Venue : Scudder Auditorium

Themes : Women's Health, Adolescent Health

Chair : **Dr. Rosalind Conway**

Time	Topic	Name
4.15-4.30 pm	Psychosocial profile of the wiwes' of alcoholics and Nonalcoholics	Dr. Revathy
4.30-4.45 pm	Ramification of adolescent sexuality, prevailing attitude and causal factors in unwed pregnancy	Dr. P.Mangala Gowri
4.45-5.00 pm	Role of ANMS in computer based HMIS in Jharkhand	Dr. Rajeshkumar
5.00–5.15 pm	First Aid training for the rural youth	Mr. Devan Prabhudoss

19th September 2008 - 4-15 - 5-15 pm

Venue : CHTC Auditorium

Themes : Non-Communicable diseases - Immunization, quality Improvement Service and Leadership

Chair : **Dr. Maya Patlia**

Time	Topic	Name
4.15-4.30 pm	Assessment of energy expenditure and body Composition in diabetes	Miss Mercy Bastin
4.30-4.45 pm	School teachers and routine immunization	Ms. Kriti Rani
4.45-5.00 pm	The role of Transactional leadership in influencing a group	Ms. Sridevi. S
5.00-5.15 pm	Quality improvement services in nursing	Prof. Indira

19th September 2008 - 4-15 - 5-15 pm

Venue : MHC - Hall - 1

Themes : Nutrition, Adolescent Health and Innovation in Teaching and learning in Community Health Nursing

Chair : **Mrs. Helan Rajamanickam**

Time	Topic	Name
4.15-4.30 pm	Nutritional status of primary school children in selected rural communities	Ms. R. Gandhimathy
4.30-4.45 pm	Effectiveness of training module on knowledge of first aid among the villages youth in a selected rural community.	Ms. M. Jayalakshmi
4.45-5.00 pm	Knowledge of adolescents regarding drug used for common used ailments.	Ms. Harmanpreet Kaur
5.00-5.15 pm	Factors influencing the learning of Community health nursing	Ms. M.Navaneetha

19th September 2008 - 4-15 - 5-15 pm

Venue : MHC - Hall - 1

Themes : Quality Improvement Services and Non-Communicable Disease

Chair : **Ms. Jaeny Kemp**

Time	Topic	Name
4.15-4.30 pm	Knowledge, attitude and level of satisfaction of health care consumers in utilization of health	Ms. D.Celina
4 30-4 45 pm	Study to assess the knowledge on monitoring of health status among rural women	Ms. Karpagalakshmi
4 45-5 00 pm	Socio economic project – Goat Unit Devadosan	Dr. Jayaseelan M
5 00-5 15 pm	Knowledge and practice in prevention of selected complications of diabetes mellitus among newly diagnosed diabetic patients and after structured teaching programme	Ms. Priscilla

POSTER PRESENTATIONS

Theme : **COMMUNICABLE DISEASES**

S.No.	Topic	Name
1.	Comparison of knowledge and attitude on optional vaccines among mothers of under five children between selected rural and urban communities	Mrs. P. Sivagami
2.	Public health importance of Avian Flu	Ms. V. Bharath Sorubarani
3.	Application of Epidemiology in community oriented nursing	Ms. B. Kalpana
4.	Avian flu	Ms. Tamilselvi Ms. Revathy Ms. Kiruthika

Theme : **WOMEN'S HEALTH AND ADOLESCENT HEALTH**

S.No.	Topic	Name
1.	A model to reduce the perinatal mortality	Ms. Vathsala Sadan Ms. Greeda Alexander Ms. Irene Dorothy
2.	Effectiveness of dietary counseling regarding anaemia among adolescent girls	Ms. Pon. Kiruthinaveni
3.	Adolescent sexual and reproductive health for girls	Ms. M. Thenmozhi
4.	Culture and Teen care	Ms. K. Latha
5.	Eve's Road to health	Mrs. Janey kemp
6.	Empowerment of women in health	Mrs. Jaeny kemp
7.	Quality improvement services in women's health	Ms. K. Thamaraiselvi

Theme : **INNOVATIONS IN TEACHING AND LEARNING IN COMMUNITY HEALTH NURSING**

S.No.	Topic	Name
1.	Innovation in teaching and learning in community health nursing	Mr. G. Srinivasan
2.	Innovations in teaching and learning in community health nursing	Ms. Geetha T. Ms. Jyothy
3.	Innovations in technology in community health nursing education	Ms. M.A. Sahbanathul Missiriya
4.	Multi media teaching and learning in community health nursing	Mrs. Nisha Clement

Theme **FAMILY NURSE RACTITIONER, OCCUPATIONAL HEALTH, NURSING NUTRITION**

S No	Topic	Name
1	Role of nurse educators in preparing family nurse practitioners	Ms. G. Thilagavathy
2	Occupational health nursing	Mr. M. Kandasamy
3	Competencies of family nurse practitioner	Mr. M. Kandasamy
4	Prevalence of malnutrition among under 6 children	Mr. Abhishek Suroy Ms. Radha Saini Ms. Harmanpreet Kaur Ms. Kirti Rani

Theme : **QUALITY IMPROVEMENT SERVICES**

S.No.	Topic	Name
1.	Comparative survey to assess the provision and utilization of water supply and sanitation facility in urban and rural areas	Ms. Saramma Samuel
2.	Quality improvement services - Occupational health	Ms. V. Hemalatha, Ms. Priya Ms. Parvathavarthini
3.	Community health nurse makes a difference in health care	Mr. I. Clement

Theme : **NON COMMUNICABLE DISEASES**

S.No.	Topic	Name
1.	Community Based Palliative Care	Ms. Shakila Murali
2.	Identification of high risk adults for hypertension, disabetes mellitus in a rural community	Ms. Maheswari Ms. Julie Sylvia
3.	Assessment of knowledge and prevalence of selected risk factors of hypertension among adults	Mr. V. Chithravel
4.	Risk factors in seizure disorders	Ms. Deepa Raman
5	Junk food and obesity	Ms. Shanthi Derma
6	Non communicable diseases	Mr. Mathew Sony Ms. Sujatha J. Ms. Tamizhkodi
7.	Obesity	Ms. Jansirani
8.	Comparison of proficiency of metered dose inhaler (MDI) use in asthma control	Ms. Vedha Radha Dr. D.J. Christopher Ms. Beulah Premkumar
9	ABC of smoking cessation	Ms. Beulah Premkumar

Theme : **GERIATRIC CARE**

S No	Topic	Name
1	Quality improvement service in geriatric care	Ms. Annie Freeda
2	Quantity Improvement Services - elderly care	Ms. K. Rajarajeswari Ms. Shikha Moni

PICTORIAL ACCOUNT OF COMMUNITY HEALTH NURSING WORK IN COLLEGE OF NURSING, CHRISTIAN MEDICAL COLLEGE, VELLORE

Dr. CHELLARANI VIJAYAKUMAR

The purpose of this account is to give a glimpse of the community work which started in the 1950s, and progressed into the 1970s until now in the following photos. Dr.Miss.Pauline E.King captured memorable moments in 1955 through her love for photography. Her works include 'Padmini's choice', a documentary made in 1966 that showcased the preparation of a nurse from admission upto graduation.

The rural programmes were started in 1947 in Kavanur and in 1952 in the Kaniyambadi villages attached to Rural Health centre, Bagayam. There was an urban programme in the town Vellore. The rural programmes have become very busy, bigger rural hospitals each with an outreach programme covering one community development block (RUHSA & CHAD programmes). In 1987, another nurse managed rural programme was added (CONCH).

The current photos portray nurses engaged in different activities both in the hospitals and in the communities. The community work photos show nurses working with families, school children, youth, women, old people, village health worker, village leaders, so on and so forth.

There may be nurses involved in similar work in other institutions in the country.

PIONEERS OF COMMUNITY HEALTH NURSING

Dr. CHELLARANI VIJAYAKUMAR

Ms. MARTHA ROSE and
Ms. KAY GREENFIELD
(C.M.C.Ludhiana)

The Medical Missionary work in CMC was started in the year 1881 by the Greenfield sisters, Ms.Martha Rose and Ms.Kay Greenfield (one of them a nurse). They envisioned the contribution of women as nurses in the field of health care and education. This pioneering Medical work was started with a dispensary to give simple treatment and advice to women patients. It became the precursor of the Medical Training and Health care service programme making a significant contribution to the health standards with special emphasis on health care in the rural areas.

Miss KATHALEEN NORRIS

A missionary from USA, Miss Kathaleen Norris was instrumental in starting the first organized Community Health programme in College of Nursing, Christian Medical College, Vellore during 1947.This was before the government programmes were planned in 1952. She planned the urban health services in Vellore town and the Rural programme in the village Kavanur. She planned the clinical experience for the first batch of B.Sc. Nursing students and thus became the pioneer in the institution. In 1962, she went to help in the ETCM Hospital & School of Nursing, Kolar, Karnataka and worked for four years managing the Community Health programme as Director and helping in the student education before leaving to USA.

Dr. Miss PAULINE E.KING

Dr. Miss Pauline E.King arrived in India from rural Pennsylvania, USA in 1955 to help in the Christian Medical College, Vellore to teach the Medical students in Public Health. She was instrumental in helping Dr.Mrs.Kasturi Sundar Rao to start the Rural programme in Kaniyambadi Block. She completed PhD in 1963 and her study was on Utilization of Nurses in Primary Health Centres. She initiated Masters Programme in 1969 in College of Nursing, Christian Medical College Hospital, Vellore. She continued teaching Community Health to different groups of students in the College. She got involved in Red Cross Society, All India Women's Conference, CASA activities for Women and Children. She set up a Creche in the Urban programme.

She worked for many years as a Professor even after her retirement in 1988. She has worked both in urban and rural areas and has done many cross cultural studies. She was the Pioneer for Leprosy Rehabilitation in the C.M.C.Hospital and had the vision to found the Audio Visual Unit at the hospital where treated leprosy patients helped in preparing Audio visual aids and printing material. In 1969, she created a place where orphans, destitute women and the elderly could live together and support themselves which is named as Mudhiyor Balar Kudumba Grama Pannai at Kasam, In 1979, she has received the President's award for her meritorius service to the community.

Mrs. ACHYAMMA JOHN

Mrs. Achyamma John is a retired Dean, and Head of Community Health Nursing Department, College of Nursing, Christian Medical College, Vellore. She belonged to the first batch of B.Sc (1946) nursing students of College of Nursing, Vellore. She spent all of her service period in the field of Community Health after completion of Master of Public Health in USA. In 1949, she was instrumental in developing the first rural health programme in a small village called Kavanur started by the College of Nursing. She was responsible for initiating Rural and Urban programmes. She was involved in developing syllabi for different nursing programmes and has served on the Boards of Nursing Education. As a distinguished pioneer, she was an acknowledged Consultant in the field of Community Health and was awarded by the President of India for her zeal and enthusiasm. She has been an office bearer of Indian Red Cross Society and All India Women's Conference.

Dr. (Mrs). Kasturi Sundar Rao

Dr.(Mrs).Kasturi Sundar Rao belonged to the B.Sc class of 1950 in College of Nursing, C.M.C. Vellore. She did her post graduation in Community Health Nursing at UCLA California during 1958 – 1960. She completed her doctoral education at Columbia University, USA between 1974 – 1977.

Her professional career started at the Rural Health Centre, Bagayam, Vellore along with Dr. Miss Pauline E.King and she was responsible for organizing the Community nursing service. She has served as the Deputy Dean of College Nursing, C.M.C. from 1979 to 1983 and headed the Audio Visual Unit of the institution from 1978 to 1984. She has contributed enormously to the establishment of urban and rural Community Health programmes with great dedication. She has published several papers in various Nursing Journals and has authored a text book for nurses titled "An Introduction to Community Health Nursing" in 1974

Dr. MARGARET DEAN

Dr. Margaret Dean has served the nursing profession for more than 50 years and has contributed to the growth of Community Health Nursing in the Country. She is the author for the book "Hand book on Family Home Care". She has been recognized for her outstanding services and has been awarded the khosla award for Community Health Services (1994). She has served as the Second Vice- President, TNAI., Principal & Professor, College of Nursing, Post Graduate Institute of Medical Education and Research, Chandigarh (1968 – 1982), Adjunct Professor, Queen Burough Community College, New York (1973 – 1974) and Adjunct Professor, Hostos Community College, New York (1974 – 1975

Miss GAYATHRI BANDYOPADHYAY

M. Gayathri is one of the pioneers who has richly contributed to the field of Public Health Nursing in the State of West Bengal. She has obtained her B.Sc (Hons) Nursing and M.Sc (Nursing) degree from Calcutta Univeristy. She has contributed efficiently to education, practice and research in the field of Public Health Nursing. She has held several positions and served in various capacities. She was the Deputy Director of Health Services (Nursing) West Bengal and Chairperson, Public Health Nursing Section, TNAI formerly. She has been the Principal for Regional Teachers/ Public Health Nurses Training Institute, Singur (1986–1994), Assistant Secretary, Public Health Nursing Association (West Bengal), Fellow, Indian Public Health Association in 1993.

Miss. TAHIRA HASHIM ALI KHAN

Ms. Tahira Khan has served nursing profession for 32 years with utmost devotion. She has contributed immensely to the development of Nursing Education in Andhra Pradesh. She has contributed to the field of Community Health by representing India in global health forums and served as a Consultant in World Health Organization. She has various publications to her credit that are noteworthy at national and international levels. She held the position of Principal, Government College of Nursing, Hyderabad. She got the President's award for Best Nurse in 2006.

Miss. BERYL A.DEVANESAN

Ms. Beryl Devanesan is a recipient of President's National Award for her outstanding contribution towards promotion of Nursing and Community Development. She has done her General Nursing in Queen Elizabeth Hospital, Birmingham, UK (1947 - 50), Diploma in Nursing, Teaching Govt. General Hospital, Madras (July 1955 to March 1956) Public Health Nursing, All India Institute of Hygiene and Public

Health Calcutta (July 1957 to March 1958). M.Sc (Nursing) Public Health Nursing & Teacher Preparation Programme, School of Nursing & School of Public Health, University of North Carolina, USA (September 1970 to May 1972). She has contributed to the field of Community Health Nursing, by teaching public health in nursing schools, developing clinical areas, conducting health projects, participating in Primary Health Centres activities, publishing papers and involving in research activities. She had been deputed to the gazetted post at Avvai Rural Medical Services, Gandhigram (1959 - 1961). She has served as Principal in Government College of Nursing, Chennai and Bishop's College of Nursing, Dharapuram. She has several awards to her credit.

Mrs. REENA BOSE

Mrs. Bose, during the last 50 years has served the nursing profession with utmost care and dedication. She has been instrumental in the formulation of policies, monitoring and evaluation of programmes at the national and international level. She has served as the First Vice President, TNAI; Deputy Director of Health Services, Govt. of West Bengal; Principal Nursing Officer for Public Health Nurses, School Health and Health Education Section, Directorate of Health Services, West Bengal and Vice – President, Indian, Nursing Council. During 2001 – 2005, she has served as the President of Common Wealth Nurses Federation. She has been President of Nurses's League of C.M.A.I.

BEST PRACTICES IN MCH SERVICES IN TAMILNADU

Dr. S.ELANGO, MD, DPH, DIH

Introduction

The National Rural Health Mission (NRHM) has been launched in Tamil Nadu with a view to bring architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery. It aims to improve the health status of the people, especially those who live in the villages. The vision is to provide universal access to equitable, affordable and quality health care services which is accountable at the same time responding to the needs of the people. The programme is for the period *2005-2012*. The programme is funded by Government of India.

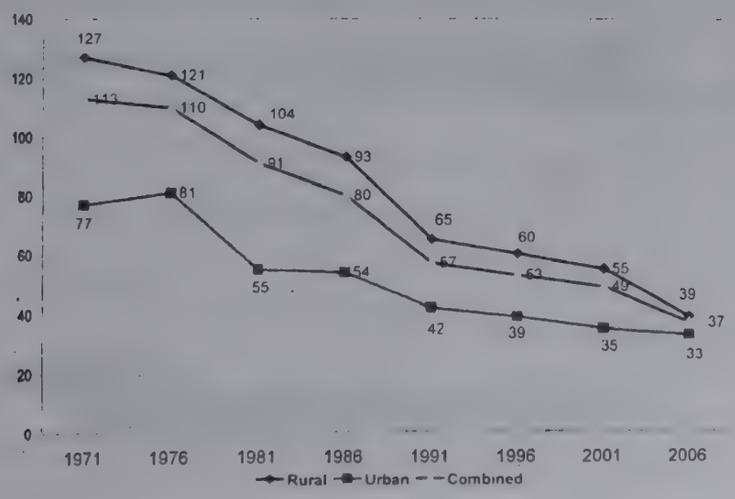
Objectives

* Reduction in Infant mortality and maternal mortality
* Universal access to Public Health Services - Women's health, child health, drinking water, sanitation and hygiene, nutrition and universal immunization.
* Prevention and control of communicable and non-communicable diseases . Population stabilization - Gender and demographic factors
* Access to integrated comprehensive primary health care
* Revitalizing local health tradition and mainstreaming ISM
* Promotion of healthy life styles

RCH / NRHM Goals

Indicator	Current Status (2006)		Target (Tamilnadu)		
	India	Tamilnadu	2008	2010	2012
IMR	57 (SRS)	37 (SRS) 31 (NFHS-3)	< 25	< 20	< 20
IMR	301 (2003)	92 (Reported 2006)	< 80	< 60	< 45

Trend of IMR in Tamilnadu



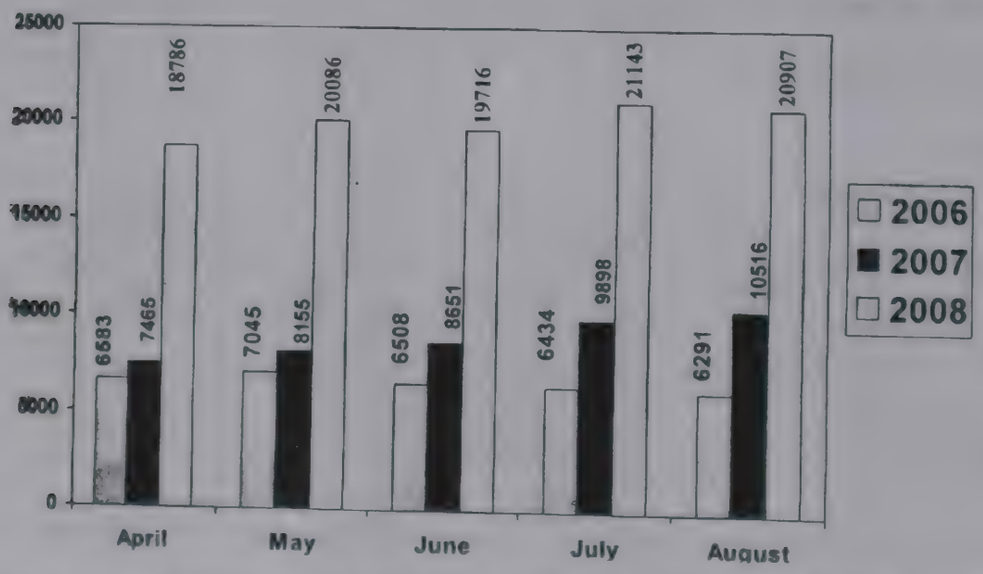
Maternal Deaths Reported

Schemes under RCH - II 24 Hours Delivery Care Services in PHCs

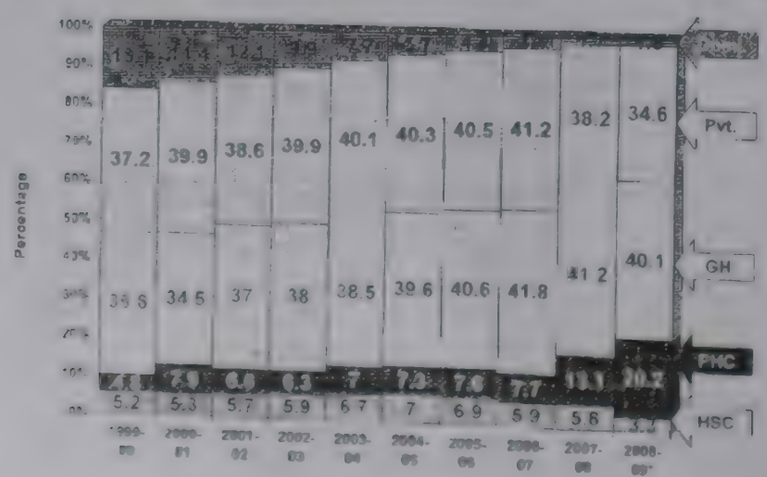
Countries which have high level of skilled birth attendants at birth have lower levels of MMR. Tamil Nadu is committed to decrease the number of maternal deaths on par with developed nations across the world. In this direction, the PHCs were strengthened to provide 24x7 hour delivery care services. In Tamil Nadu, Staff nurses were recruited and placed in 1000 PHCs providing 24 x 7 delivery care services. This intervention has led to a dramatic increase in the number of deliveries being conducted in the PHCs. To sustain this activity, this intervention is being continued and extended to remaining 421 PHCs from 15th September, 2008. Therefore all PHCs in Tamilnadu becomes 24x7 PHCs providing round the clock delivery care services.

Graph showing increase in deliveries conducted at PHCs

PHC Deliveries Performance 2006,2007 & 2008 (April - August)



Graph showing increase in the proportionate share of deliveries conducted at PHCs among other institutions



PHC Delivery Performance

Deliveries conducted at PHC during the period Aug' 06 to July' 07	89,021
Deliveries conducted at PHC during the period Aug' 07 to July' 08	1,99,484
No. of Deliveries increased for the Year	1,10,463
Deliveries conducted at PHC during this period	124.09 %

How we are able to achieve?

* Staff nurses are available round the clock in 1000 24 x 7 delivery care service PHCs.
* The labour rooms and toilets are kept clean in all PHCs.
* Clean wards
* Scan facility and Semi Auto Analysers are available in all Block PHCs and UG PHCs.
* Blood storage facilities established
* Emergency Obstetric and newborn care services available round the clock in all the upgraded PHCs.
* All the PHCs are provided emergency drug tray in the labour room with necessary drugs.
* Regular EDD motivation campaign is organized at HSC level in all PHC's. Here AN check-up, lab investigations are done.
* Regular EDD motivation campaign is organized at HSC level in all PHC's. Here AN check-up, lab investigations are done.
* Birth companion scheme implemented.
* Field visits are made by the Delivery Task Force Team (DTFT) MOs and Staff nurses for motivating the AN Mothers.
* Valaikappu function - Bangle wearing ceremony to antenatal mothers organised by the PHCs which reduces the gap between PHC and the AN Mothers.
* PHC infrastructure facilities improved.
* Beautiful gardens developed.
* Dr. Muthulaksmi Reddy Maternity benefit scheme and JSY
* Free nutritious lunch to AN mothers who come for AN clinic and free food to delivered mothers at PHC and post natal mothers who come for Sterilization.
* PHC day Celebrations conducted
* EDD monthly chart prepared at PHC and monitored by PHC Medical Officer
* Maternity picnics organised at PHCs
* Mothers feel comfort at PHC after delivery with privacy and entertainment through cable TV
* Free transport for deliveries
* Solar Water Heater to provide hot water at PHCs

Gestational Diabetes Mellitus (GDM)

With the modern life style, change in the food habit and the culture, the prevalence of the non communicable diseases like diabetes and hypertension is on the rise. Gestational diabetes causes abortion, still birth, big baby, birth defects, respiratory distress and neonatal death and sometime even maternal death. Gestational diabetes could be easily diagnosed at early pregnancy with the semi auto analysers supplied to the PHCs. The

treatment was given at the PHC level and safe delivery could be ensured. The doctors are being given training and adequate drugs were provided to the PHCs. Awareness programmes were conducted in the community.

Details	2007-08	2008-09 (Upto August)
No. of AN mothers tested (GTT) for Gestational Diabetes	59841	24792
No. of AN mothers found to have Gestational Diabetes	1578	749
% of AN mothers having GDM	2.6%	3.0%
No. of mothers with GDM tested (GTT) during PN period	2158	2776
No. of PN mothers found to have impaired GTT	56	133
% of PN mothers having GDM	2.6%	4.8%

Provision of Outreach Services through Mobile Medical Units

Under RCHP, the Outreach Services play a major role where the health care services are provided to the people as nearer to them as possible. Through the fixed day outreach visits. to the villages, the entire reproductive health services are made available at the doorsteps of people. The elderly people, disabled and women with newborns are among benefited by this programme.

The following services are provided in the villages by the team headed by the doctor

* Treatment of minor ailments
* Antenatal care
* Post Natal care, Newborn care.
* Management of RTI/STI cases
* Diabetes and hypertension screening and treatment . TB & leprosy case detection
* Laboratory services.
* Nutrition counselling
* Health education.
* Identification of issues regarding water, sanitation and hygiene in the area for corrective community action.

Under NRHM, 100 mobile outreach units were formed with a dedicated team of Medical Officer, Nurse, Driver and Sanitary Worker in addition to the existing 46 mobile outreach units. In the year 2007-08 another 100 MMUs were established. During 2008-09 it is proposed to establish the remaining 139 dedicated MMUs by extending the existing scheme, so that all the 385 blocks are covered. Generally, the teams cover all the remote villages in one month schedule.

Hiring of Anaesthetists and Obstetricians for providing Emergency Obstetric Care Services

During delivery. mothers are referred for want of Anaesthetists and Obstetricians. 30% of the mothers died on the way to referral centers. This hiring programme has helped in reducing the maternal mortality by 38% in 2007. Also. this hC1S increased the number of Caesareans performed in the secondary institutions.

Caesareans in PHCs

In India. and in Tamilnadu. Caesarean are conducted at Primary Health Centres by hiring Anaesthetists and Obstetricians

Caesarian conducted at Vellore HUD

PHC	Since	No. of CS (upto June 08)	Average / Month
Banavaram	July 07	352	29
Lalapet	Sept. 07	141	14
Anaicut	Nov. 07	81	10

Improving institutional delivery of Below Poverty Line (BPL) women

Dr. Muthulakshmi Reddy Maternity Benefit Scheme

Government of Tamil Nadu is committed to the health and welfare of the women and children particularly the poor and vulnerable. Therefore the State Government with a view to provide financial assistance to poor pregnant women launched Dr. Muthulakshmi Reddy Maternity Benefit Scheme on 15.9.2006, Under this scheme Rs.3000/- is given to the pregnant women from Below Poverty Line families three months prior to the expected date of delivery and Rs.3000/- after delivery.

This cash assistance is given to compensate the wage loss incurred during last 3 months of pregnancies and to get good 'nutritious food. All pregnant women living below poverty line are eligible to receive the benefit for two deliveries. The scheme also has been extended to Srilankan pregnant women refugees.

All pregnant women eligible for the benefit can get the application form from the Village Health Nurse during 7th month of pregnancy. They are instructed to submit the filled in application to the Village Health Nurse. After verification of the details given in the application, the Village Health Nurse forward the application to Block Medical Officer through Medical Officer (PHC). After scrutinizing the application, the Block Medical Officer will claim the amount from the treasury and disburse the cash assistance by A/C Payee cheque to the pregnant mothers.

The pregnant women who are members of Farmers' Social Security Scheme are also eligible to get this cash assistance irrespective of the income limit.

From 15.9.2006 to 31.3.2007 a total of RS.100.00 Crores have been distributed to 241,095 beneficiaries. During the year 2007-08 a sum of Rs.300.00 Crores have been sanctioned and '675,132 beneficiaries were benefited. During the year 2008-09 a sum of Rs. 250.00 Crores have been sanctioned and 74,859 beneficiaries were benefited.

As a result of this assistance, weight gain during pregnancy is showing improvement. Antenatal clinic attendance is steadily increasing, PHC deliveries have increased by 124 % and home deliveries dropped down from 4% to 1%.

Details	2006-07	2007-08	2008-09
Amount Distributed DDHS (in crores)	100	300	250
Amount spent (in crores)	100	296.34	37.66
Total beneficiaries	2,41,095	6,75,132	74,859

Janani Surakha Yojana

Janani Suraksha Yojana is one among the schemes under Phase II of RCH which aims at reducing the maternal and infant mortality by focusing on skilled attendance during childbirth for the below poverty line families. For Institutional deliveries, Rs. 700/- is given to rural area and Rs. 600/- is given to urban area. Rs. 500/- is given to both rural and urban area for domiciliary deliveries. The BPL criteria is not applicable for the SC and ST population.

Details	2007-08	2007-08
Target	401955	147248
Total beneficieris	229609	53599
Percentage	57.1	36.4

HEALTH ECONOMICS FOR NURSING PROFESSIONALS

Dr. KR JOHN, *MD*
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Economics can be defined as the science of choice of alternative use of scarce resources when faced with unlimited wants. It should also be remembered that the topic covers the use of resources and need not deal directly with the money.

Efficiency and effectiveness data are usually from epidemiological research or metaanalysis. This need to be linked with economics related data for making the best choice. When this is done this is called efficiency analysis.

The study of health economics has the following applications. It forms the scientific basis of clinical practice using the optimum use of scarce resource. The science also helps in the choice of appropriate technologies .The principles of health economics helps to make investment decisions and sustainability analysis. There is going to be more use of the principles of health economics with globalization of health care and insurance.

Nursing care forms a major resource in the manpower for all health care interventions. The nursing care technologies need to be chosen with care so that cost-effective technologies can be popularized.

Making policy change from economic research is possible when the following aspects of health economics research is taken into consideration.

The topic chosen must be a relevant clinical research question with choices need top be possible to be chosen from. There should be sufficient magnitude of costs and effects difference so that there is a significant contribution possible at the end of the study. The costs and effects need to be calculated credibly as per the intentional standards. The conclusions made should be valid. The findings should be disseminated well. Implementation of the study findings according to the best choice should be possible to effect policy change.

The following are 2 sample studies which were done in Christian Medical Collage and hospital to replace the current clinical practice by a new one. The cost effectiveness of neonatal care after normal Caesarean with admission to the nursery or with out admission in the bedside of the mother. This study has shown there is no difference between these babies who are treated at the nursery and at the bedside with mother. The earlier policy was to keep all normally born children after Caesarean at the nursery. At the end of the study the policy was changed to admit all newborn babies with normal outcome after Caesarean. This has helped to create surplus beds for more sick newborn babies. Another example of change in policy possible was to care for patients after mild neuritis after leprosy. The current policy was to admit all patients in the department of dermatology's inpatients. A randomized controlled clinical trial with inpatients, and out patient care arms was instituted to see the difference in the costs and the effects. It was found that the hospitalization for mild neuritis although increased the extra costs to the extend of 18,000 Rupees, this has no difference in the out come (effects) inters of quality of life of the patients. the sensory and motor involvement. It can be recommended that the specialty of health economics need to be developed at all levels of courses relating to nursing care

SCIENTIFIC WRITING

Dr . GAGANDEEP KANG
Addl Vice-Principal (Research)
Christian Medical College
Vellore

The purpose of writing a scientific paper is to communicate with an audience of readers.

Before writing the first line of a paper, it is crucial to identify the audience. Precisely which aspects of the work should be presented, and how the paper should be written will critically depend on the level of expertise and on the interests of the audience.

Scientific articles are neither mystery stories, intended to surprise the reader with a discovery, nor diaries of every successful and unsuccessful experiment performed. Instead, the major discoveries are set out in the article's first section. The writer's goal is to present his or her findings and persuade the readers with his or her interpretation of the data. Journal articles are divided into sections, each with a specific purpose. Although every journal has a particular "house style" for the way it formats and names the sections of the scientific articles it publishes, a generic scientific article would include the following:

* **Title** : A well-written title gives information about the research. The names of all scientific contributors are usually listed immediately after the title. By convention, the scientist who performed most of the work described in the article is listed first, while the last author is usually a senior scientist who secured funding for the work and under whom it was performed.

* **Abstract** : Some journals call this the "summary" because it must concisely describe the experimental question, the general methods and the major findings and implications of the experiments. It is generally limited to 250 words because the text is typed into literature databases, such as PubMed. A well-written abstract will include likely "search words" because searching databases is a major way scientists find articles of interest.

* **Introduction** : The central experimental question and important background information are presented in this section. Relevant and established scientific knowledge is cited in this section and then listed in the *References* section at the end of the article. Introductions are intended to lead the reader to understand the authors' hypothesis and means of testing it.

* **Materials and Methods** : All experimental procedures and reagents are described in detail sufficient for another researcher to reproduce the findings. This section must be accurate and complete, if the discoveries are to be validated and then extended by others.

* **Results** . The data are presented in this section, giving other scientists an opportunity to judge their merit The findings are described with words and also illustrated using figures and tables. Figures are used to facilitate the interpretation of the data and have accompanying explanations, called "legends."

* **Discussion** : In this section, authors may present a model or idea they feel best fits their data. They also present the strengths and significance of their data. Some journal articles fuse "Results and Discussion" into one section, but when they are separated a reader can easily distinguish the data collected from the authors' interpretation of it.

* **References** : Scientific progress builds on existing knowledge, and previous findings are recognized by directly citing them in any new work. The citations are collected in one list, commonly called "References," although the precise format for each reference section varies considerably. Some journals ask that citations be listed alphabetically, whereas others require that they be listed by the order of appearance in the text.

The most important technique to use when planning to write a scientific paper is to develop an outline. What is an outline? It consists of a list of topics, information and arguments which will be used in the paper. The purpose of the outline is to divide the task of writing the entire paper into a number of smaller tasks. Ideally, each item in the outline will cover only a page or two. Often the items of your outline will become the sections and subsections of the paper.

All scientific papers should attempt to follow the 'Uniform Requirements for Manuscripts Submitted to Biomedical Journals' which lays out the minimum requirements that a scientific article must meet to be considered for publication in a peer-reviewed biomedical journal. Many journals have adopted it as a standard and refer to it in their instructions to authors and all medical authors should be familiar with it and review it from time to time. It is available on the internet at http://www.icmje.org/index.html#top and has also been published in several journals over the years.

Scientific writing is a skill that comes with planning and practice. A paper written in a sloppy, confusing, obscure and misleading manner will almost certainly produce less impact on the community than a clear paper. The format and structure presented in this session will be a general one; the various scientific journals, and specific disciplines, utilize slightly different formats and/or writing styles. Mastery of the format presented will enable adaptation to most journal- or discipline-specific formats. However, the writer must practice writing and thinking within this structure, and, learn by example from the writings of others, learning the nuances of this style and format will be enhanced as by reading the scientific literature, paying attention to how professional scientists write about their work. This will result in an improvement in scientific writing skills by repeatedly practicing reading, writing, and critiquing of other's writing.

EVIDENCE BASED HEALTH CARE

Dr Abraham Joseph and Dr Sulochana Abraham
Former Professors and Heads
Community Health department, CMC, Vellore

In 1945, the Joseph Bhore committee made recommendations for developing India's Health care system. Since then several committees have been formed to recommend changes in the national health care system. What is the basis of these recommendations?

Is it based on the impressions and personal experience of the committee members or is it based on scientific facts? Very few decisions have been based on scientific data. Why? It is partly because there is no scientific data based on which policy and strategies could be planned.

The delay in taking a policy decision to include measles in the Universal Immunisation program is a good example. This was discussed at length by public health and paediatricians. The argument of the paediatricians was that measles does not cause many problems. The data from teaching and district hospitals did not show too many measles associated deaths in the government hospitals. Why did public health specialists have difficulty in convincing the clinicians? It is well known that measles affects poorer people more the rich. It is also well recognized that a child with measles irrespective of the socio economic back ground will not be taken to a hospital for fear of offending the goddess "Mariamma". Even if a child is taken to hospital it is in the terminal stages and the child dies. When the relatives realize that the child is likely to die they prefer to have the child die at home for several reasons one being the cost of transporting a dead body compared to a live sick child. It was only after population based data became available and that the case fatality could be as high as 16 – 20 % and the long term sequel even higher that measles was included in the Universal Immunisation Program. This delay cost many millions of lives.

The deficiency of scientific data from population based studies was highlighted several years ago by the Health Commission. A study of the research supported by ICMR showed that less than 10 % of the studies were population based. Most were Basic research with little relevance to the common health needs. It is more exciting to do research on rare conditions than on the current health problems. The need of the hour for good health planning is scientific data. This is what I understand as "evidence based health care."

Cost and time are two reasons for not wanting to look for evidence. This is not true. It does not take time to collect good data nor is it expensive if a good health information system is established. The problem in our country and elsewhere is that we collect large volumes of information but do not convert it into useful data which can be analysed and acted on.

The Community Health and Development program of the Community Health Department CMC has established a very comprehensive information system for Kaniambadi Block. Based on the information so collected several changes have been introduced to improve health coverage.

This paper on evidence based health care illustrates how a high risk card for ante natal care was developed based on perinatal and maternal mortality rates. By using this high risk strategy it was possible to improve the quality of care by giving more attention to those who needed it most and to a lesser extend to those who did not have a known risk. The perinatal mortality rate decreased from 56 per 1000 live births in 1986 to 40 in 1990 and 31 in 1996.

If planning is based on evidence and strategies developed based on the resources available, it is possible to improve the health status of those who need it most, the marginalised, significantly. It needs sincerity, commitment and a scientific approach.

NURSING LEADERSHIP IN COMMUNITY HEALTH

Dr. Mrs. MARY SULAKSHINI IMMANUEL
Former Dean, College of Nursing, CMC, Vellore
Director of Nursing, Tiruvalla Medical Mission, Kerala

Theme : Evidence based Health care

Evidence based health care is a way of thinking and practicing that requires discipline and practice to continually assess 'where is the evidence for this? And to weigh the validity and reliability of daily practice activities.

- To get the research into practice.

For four decades the nurse researchers are interested in understanding what influences the use of research findings in clinical practice and knowledge translation. Research utilization remains undeveloped in nursing to offer empirically based or tested interventions for enhancing research uptake.

Carole Estabrooks and colleges (2003) used a frame work as a heuristic device to help make sense of the many variables and interactions that occur in practice that is "Promoting Action on Research Implementation in Health Services (PARIHS)" but did not include individual or context influences.

Dopson et al (2005) did extensive qualitative, case study research and theorized that context and social processes are central to knowledge production and use.

Greenhalgh et al (2004) reported an exhaustive systematic review on determinants of diffusion, dissemination and implementation of innovations in health care that most studies concentrated on a few components and failed to consider contextual aspects and interactions among variables.

Rogers et all (2003) argue that innovation diffusion is influenced by individual, specific and organizational characteristics and it is a social and communicative process.

For research utilization among nurses, three levels of influences are observed.

Individual – level influence, Speciality - level influence, Context – level influence.

I. Individual level : Estebrooks et all (2003) identified 20 studies in a systematic review of the relationship of individual characteristics for research use - They were in six categories.

a. Beliefs and attitudes
b. Involvement in research activities,
c. Information seeking
d. Professional characteristics,
e. Educational level
f. Socio Economic factors

Apart from age, sex, educational level, reading activity - Nurses use of internet have influence whereas Emotional Exhaustions counter productive due to work overload, high levels of burn out (No energy or intutition).

II. Speciality level : Related to Unit culture,

Communication pattern, patterns of decision making, Characteristics of nurses, process of facilitation, context where particular ideas, activities, people or events valued more highly than other shapes the behaviours.

III. It is the environment where proposed change occurs.

1. The nature of evidence being used
2. Quality of context in terms of coping with change
3. The type of facilitation needed to ensure a successful change process.
4. Context is constituted of culture (a value, learning oriented culture, receptive to change.
5. Leadership (a clear transformational leadership supporting team work and staff involvement in decision making).
6. Evaluation (effective feedback mechanism through multiple Methods of evaluation at various levels of performance.

Implementation : (Implementation science) (Marita et al 2005)

Implementation science is the investigation of methods Interventions (strategies) and variables to influence adoption of evidence based health care practices by individuals and organizations to improve clinical and operational decision making and includes testing the effectiveness of interventions to promote and sustain use of evidence based health care practices.

Decision Theory for knowledge translation science : (Buckhall 2007)

Decision theory : Two cognitive modes of decision making are intuition and analysis – They play a key role the way research is identified, approved, and integrated into clinical practice decisions that impact on patient outcomes.

Research findings become evidence when an individual practitioner decides that the information is relevant and useful to a particular circumstance.

For research translation to occur research evidence needs filtering, interpretation, and application by the individual to a specific situation.

For this reasons, decision science is complementary to knowledge translation science. Both aim to support the individual to decide the appropriate action in a dynamic environment where there are masses of information which is (uncensored) readily available.

Human judgement and decision making are important intellectual activities, particularly in supporting clinical decision. Human judgement methods are explored based on intuition, experience and personal insight.

Cognitive modes of information processing are one intuition and Analysis

Intuition Model is rapid, unconscious, averaging mode of data, heuristic, tacit of low constituency – moderate accuracy.

Analitical Mode is slow, conscious, consistent, usually accurate and systemic and able to combine large volumes of information using more complex principles than averaging, rational mode.

Thinking is both intuition and analytical and this work parallel.

The future studies needed :-

There is a need to create an international research community which includes researchers, policy makers and clinicians of various health disciplines.

Studies are needed using advanced technique in the examination of the process by which knowledge is moved to action in Health care settings.

Lastly, an example of Best practice and evidenced Intervention inequalities is presented on 'Diet and Nutrition' as one of six health behaviours for the improvement of community health care.

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Dr. Mrs. MARY SULAKSHINI IMMANUEL

COMMUNITY HEALTH RELATED RESEARCH

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It is a hallmark of any professional to contribute to the body of knowledge. Nurses have unique opportunities to do so, but have failed to use the opportunities and resources.

A community health nurse has several advantages that clinical nurses do not have in terms of their active role in the community, interacting medical and nursing sciences with sociocultural and practical realities of the people among whom they work. Research is a means of answering relevant questions and solving problems. Operational research tries to solve problems related to drug deliveries, drug consumption, help seeking habits, accessibility and acceptability of nursing services, appropriate health care, feasibility and adaptability of known health practices, constraints in utilizing and adhering to a treatment schedule, etc., etc.

Clinical and epidemiological research deals with evidence based nursing knowledge and practice, seeking to recommend more effective means to solve health problems. India is labelled as a "developing" country for the past 50 years !! Are going to be called "developed" some day or relegated to an "underdeveloped" nation.

Despite high sounding community health programs such as ICDS, NRHM, etc., the benefits do not seem to reach the target populations, and vast rural and semi-urban areas of our country are eking out hand- to- mouth existence, and we are still holding on to the lowest ranks of the International Human Development Index scale. WHY ? I strongly feel that health professionals especially in the community health area have let us down, including Community Health Nurses !!

It is not too late ! If only every community health nurse in every school or college of nursing takes up serious research on any relevant and urgent topic, I am sure that a significant dent will be made in solving critical problems of community health.

Some critical areas for research are in identifying obstacles in accessing optimal maternal and child health care, control of communicable and life-style related diseases, management of domiciliary care of disabled or chronically ill, best nursing practice in resource-constrained situations or poor environment, etc.

There are several reasons why community health related research is not undertaken and I shall briefly list them for your consideration:

1. Research is for academics or for M.Sc theses; not to solve real life problems
2. Research methods are not clear or difficult to follow
3. Research means statistics, and statistics is a horrible subject

4. Research Guides are not available
5. Research resources are scarce
6. Research requires special expertise, which I don't have
7. Research needs time, and I don't have time as I am overwhelmed with work
8. Research is not service or training which are priorities for the School/college of nursing

I think all of the above are either myths or excuses !!

Given the definition of research as searching for evidence to solve problems, the methodology is quite simple and straight forward and consists of:

* Statement of the problem and what others have done to solve it
* What are the Research Objectives, general and specific ?
* Best study design, methodology for data collection, study tools
* Best sampling plan and minimum sample size
* Quality control of data collected and minimize nonresponse
* Data Management and statistical analyses
* Data interpretation and dissemination

A protocol describing the above steps will be helpful to guide the researcher.

Research needs a time scale and some financial resources. Occasionally some assistants may be needed.

However, the most important requirement is a person's interest and commitment.

Today, with the availability of computers at an affordable price, and software for designing questionnaires and data management, research can be done easily and economically. Many literature review sources are also available through internet.

Guidance on sampling or study designs and analyses are also accessible.

And researchable problems are also plenty, especially in community health !!.

Why not have a go at them ?

COMMUNITY ORIENTED NURSING EDUCATION AND PRACTICE : AN INNOVATIVE COLLABORATIVE MODEL

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Nursing students at all levels need to be educated to meet the health care needs of the community through the development of innovative community partnerships. The faculty of College of Nursing, Christian Medical College(CMC),Vellore had developed and implemented a Community Based Practice Oriented Education Model (CBPOEM) which includes innovative partnerships with urban and rural communities . This model has helped to establish academic health centers for primary health care and to redirect health professionals' education into the primary care sector. Historically nursing is a practice based profession and nursing education is grounded in practice. Practice based education has evolved continuously in nursing. At certain periods in history, the focus of education and practice has undergone dramatic changes, in response to the changing needs of the work place, students and society.

The College of Nursing, CMC has been at the forefront of empowering the teaching faculty and the nursing students through the integration of class room and workplace experiences. The academic programs are committed to educating students who will competently participate and work with the urban and rural communities in the development of culturally sensitive and competent health care planning. The community based practice oriented collaborative model is an educational approach that energizes the connections among work place experiences and professional education .It is viewed as an opportunity to create well moulded students, prepared to live and flourish in a continuously changing complex global environment. Work place experiences bring classroom teaching to life.(Zachariah.R,2000).

Community based practice oriented nursing education enables the students to integrate cognitive and experiential aspects of learning as they provide primary, secondary and tertiary prevention services as well as acute and chronic care for families and community as a whole. Individuals and families as viewed within the context of the multiple periods of their individual lives, in order to meet their health care needs from a culturally competent approach. The fundamental beliefs that are the philosophical foundation in the development of community oriented nursing education and practices are:

- Nursing students learn about the multiple aspects of the community and build relationships with residents and health care providers by returning to the same areas for clinical placements as they progress through the curriculum.
- Neighborhood residence and health care providers actively collaborate with the faculty of College of Nursing to share in the educational development process.
- The collaborative process provides and opportunity for community residents and academic participants to learn more about the realities of each other's worlds.

* Client centered health care developed in this collaborative model empowers both the nursing students and residents of neighborhood to become more involved in the delivery of carefully designed health interventions.

* Students learn to view the health illness continuum as a part of the total lived experience of their clients' lives (Zungolo.E. 1985).

CONCH – A COMMUNITY HEALTH NURSING MODEL

The founder of CMC Vellore – Dr.Ida S.Scudder was very much convinced about taking health care to the needy people. Realizing the need for preparing the nursing students to provide community based problem oriented nursing education, the College of Nursing evolved CONCH (College of Nursing Community Health) model with Government's approval in 1987. Our approach is to work with the Community, the Government, the private infrastructure and voluntary organizations. The nursing students are prepared to provide competent and comprehensive health care services through their experience in this rural community. This programme facilitates independent functioning of nurses. The uniqueness of CONCH model is that the teaching faculty are also responsible for providing health services in 65 thousand rural population. The objectives of the programme are :

1. To prepare various categories of nursing students to function at different levels of community health programmes.
2. To promote the health of the community through direct and indirect services for all age groups by functioning as independent nurse practitioners.
3. To collaborate with all programmes of the community and promote community development and self reliance.
4. To help nurses to function as resource persons in the various programmes of the community.
5. To organize and participate in the training of different health personnel in the community.
6. To conduct research studies appropriate to the needs of the community and use the findings for promoting health in the community.

The components of CONCH programme are education, service, training and research. The staff who are involved in the programme have qualifications which include Masters Degree, Bachelors Degree, GNMs and ANMs. We work closely with the Primary Health Centre Staff, TINP staff (Tamilnadu Integrated Nutrition Project), Block Development Office staff and Traditional birth attendants. Each community health nurse covers a population of 2500-3000 and functions as an Independent Nurse Practitioner.

The various categories of nursing students who gain experience through this programme are prepared to provide community based problem oriented health care. The core learning experiences include Community Orientation Programme (COP), family centered care, participation in clinic activities – MCH, Morbidity, Tuberculosis, Leprosy, Health Education – Action Projects, community surveys, participation in community organization, training and supervision of other personnel Viz., TBA, VHN.,Domiciliary Midwifery and simple research studies.

The type of services provided by the CONCH staff include home care of people, conducting maternal and child health clinics, treating minor ailments, health education, conducting school health

programmes, adolescent health programmes, youth meetings, mothers programmes, geriatric clubs and clinics and special camps like dental, eye, family welfare camps, AIDS and alcoholic awareness camps. Community health nurses have a vital and expanded role in recognition and primary management of some of the most diseases and problems in this rural community. Elementary health education with special emphasis on nutrition, hygiene, child bearing and rearing, and fertility problems. The community health nurses screen the expectant mothers and children using high risk approach and refer them appropriately for secondary and tertiary level care. High risk approach is the core of this programme and people are educated on various risk factors.

The staff are involved in training of village level workers, Traditional Birth Attendants, community nutrition workers, and the volunteers under the Nehru Yuvakendra. Independent departmental, interdepartmental and collaborative research studies are being carried out by the faculty of the Community health Nursing Department.

The highlights of the achievements of the programme include an increase in health awareness among the communities, better utilization of health services, 96% coverage of primary immunization, 100% antenatal coverage, deliveries by trained personnel and community participation. We are able to maintain the maternal mortality as 0/1000 LB and to reduce the perinatal motality rate from 90/ 1000LB (1987) to 28/1000LB (2007).

The future goals of the programme are to do researches in community health nursing techniques, nursing education models, establish an "evaluation package" for community health nursing programmes, develop a `self reliance' model for the rural community using the existing power structure. establish socio - economic developmental programmes and to expand the service area with an innovative approach for community based problem oriented nursing education for Colleges of Nursing in India.

Focus Group Discussions were conducted in 2006 among the staff to identify the strengths of this model. The staff felt that they could have best practice (good patient care), have job satisfaction, developed self confidence in their own ability to reflect on current nursing practice, improved the ability to identify clinical problems in order to deliver and evaluate nursing practice. They also expressed that learning is maximized through experiences located in clinical setting experiences in real life setting are effective and it empowered the students and faculty. Application of this model lead to an increase in the scope for education and service, increased productivity in faculty, optimal use of resources. Theory and clinical practice gap is bridged and it also strengthens the working relationships. The pitfalls identified were an increase in the stress level of staff and because of increase in the work load the staff felt that they could not have time for their personal welfare and family welfare.

In today's global workplace, both nursing education and practice need to promote international health. The collaborative partnership model in College of Nursing has resulted in excellent clinical experience for undergraduate nursing students. It is an individualized population focused experience for students based of principles of learning, empowering preceptors who are able to increase the scope of services and increased productivity for the faculty for research and scholarly activities. Critical reflective thinking, self directed and self guided structured approach as well as the collaborative partnership in nursing education and practice grounded in the process of critical thinking are essential for the successful implementation of community oriented nursing education and practice.

INNOVATIONS IN COMMUNITY HEALTH NURSING

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Since from last few decades, there is a spectacular change in the practice of nursing profession. The change is more identifiable in institutional nursing practice especially in cities. However the Community health Nursing practice in Rural and Urban areas is still awaiting the similar change.

To seek peoples' participation in health care management, we need to enhance our outlook towards adopting innovative approaches in the field of community health nursing.

Innovation in Community Health Nursing

Innovation as the word signifies is "the action of introducing a new method, idea or product." Innovation in Community Health Nursing may be defined as "the process of introducing creative ideas and new approaches in community health nursing practice which are directed towards promoting, preventing, maintaining and restoring peoples' health with the community focused management strategies."

Need for Innovation in Community Health Nursing.

1. There is a rapid change in the health care delivery system. 2. The focus of the care should be the client or community rather than health care providers. 3. The health care services should be tailored to meet the growing needs of the community. 4. People should be equal partners in their health care management. 5. Community focussed new approaches in health care management is more likely to be successful in terms of its acceptability and utilization.

Innovative Approach Implemented in Community Health Nursing Practice

The Name of the Programme - Youth with Nurses for Health care of People

The Objectives of the Programme

1. To develop managerial abilities in the students in practice of community health nursing by seeking peoples' participation. 2. To motivate the village youth in Health and community Building activities. 3. To prepare and involve the youth for health care of self and community 4. To enhance the acceptance of community health nursing services in the community 5. To help the youth in personality development of self and others. 6. To assist the students in widening their insight towards the community problems 7. To identify the effectiveness of collaborative activities in community health nursing.

The village selected for the programme was Khanapur, Tal Haveli, Dist, Pune with the population of 3000.

The Boys and Girls of the village, who were in the age group of 15 to 25 years were included in the project. The others were nursing students (N=30), the medical officer and nurses of PHC. The others included for the study from the village were Gramsevak, Sarpanch, Grampanchyat Members, NGO- Navsahyadri Mandal, anganwadi worker and School teachers

The health problems identified were environmental health, prevention of HIV and AIDS, School Health and detection, treatment and prevention of anaemia in Women.

The programme was carried out in four phases - Initiation and contact phase, planning phase, programme Implementation phase, evaluation phase.

The Initiation phase consisted of creating awareness, identifying youth leaders and building rapport. The activities consisted of conducting meetings with Sarpanch, Gramsevak and NGO, Youth & Families ; Identifying Influential youth leaders ; planning rapport building activities such as sports, debates, essay competitions ; Participation in Cultural activities along with Nursing students.

The planning phase included conducting training programmes and formation of groups. It consisted of activities such as conducting surveys, preparing IEC materials, verbal publicity of programes, participation in Street plays, exhibitions, puppet shows along with the students, formation of mixed groups of students & youth with nursing student as a leader.

The implementation phase consisted of activities related to health awareness in environmental health, prevention of AIDS, school health and aneamia. The activities included Creation, awareness through of IEC, Clean Home and Environment Competitions, Village cleanliness compaigns, constructing drainage lines and Latrines through Shramadan. Massive Health Education programmes, Organising Medical check-up camps, Organizing Various competitions, administration of Iron and Folic acid tablets, Providing counselling services to the Women, Cooking competitions, Indoor games Compititions, Healthy baby Compititions, Health slogan making competitions, Gynaecological Check Up Camp, etc.

The Evaluation of the Program

* The students developed managerial abilities in the practice of community health nursing by seeking peoples' participation . 90% Of the students opined that they would like to work in the community. . The constructive energy of village youth was channelised in Health and community Building activities.
* There was tremendous growth in the personality of the youth. They themselves felt that they are confident in taking care of health of self and others.
* The Youth who were participating in the programme were almost all employed in Government and public sectors as teachers, clerks, policemen. Few of them are engaged in self employment.
* One of the participants became first woman Sarpanch of the village and now she is Zilha Parishad Member.
* About 10 male participants were elected as Gram panchat members and now working as leaders of the Village.
* The community health nursing services provided by the students and youth were very much accepted and appreciated in the community.
* The collaborative activities in Health care of community were found to be very effective.

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COMMUNITY NURSE PRACTITIONER MODEL

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Introduction :

The process in Community Nurse Practice Model enables a Community Health Nurse to apply her professional skills independently within a permissible framework. In a country with a majority of population in vulnerable section justifies the need for a independent community nurse practice. In truth, the auxiliary nurse midwives function as independent practitioner within the formal health care delivery system. This needs to be extended to more qualified nurses too in the non formal way of health care delivery.

Settings :

Community Nurse Practice has its recipients of care from two settings. One is the traditional setting where, apparently normal, individuals or families live and work, such as, rural area, urban area, industries, geriatric homes, schools etc. The other setting is the hospitals from where the sick individuals after treatment are sent back to the community.

Responsibilities of a Community Nurse Practitioner in community would envisage the health assessment, ordering and procuring investigation, making clinical judgement, prescribing the essential drugs and referring the high risk causes.

However, **the responsibilities of the community nurse practitioner in the hospital** would be to follow up the discharged clients, providing physical care and educative care. In such situations, health assessment and physical care will assume the primary importance.

The independent Community Nurse Practice warrants, skill based education, training, examination and the legal protection for the practitioners.

The Independent Community Nurse Practice can flourish in non-formal set up with **Nurse Entrepreneurship,** where the nursing team functions by 'on-call', or 'call-on' form of service.

CHRISTIAN MEDICAL ASSOCIATION OF INDIA - COMMUNITY HEALTH WORK

Dr. Shoba Yohan,
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Christian Medical association of India through its member institutions are working on Community health since very early stages .

Mile stones - CMAI had started Family Planning project in 1969 among 250 member hospitals. We Did well. In 1982, we were recognized by govt. of India as leading NGO in Family planning. In 1983, CMAI shifted to community health and Family planning. Started Child Survival and Child assurance plan project for 25 hospitals. Then started Community health and Development project for 25 hospitals for 5 years. In 1986, Community health department was started. In 1987, with the help of family planning International assistance started 12 community based Family planning projects in South India and 12 Community projects in North India. Then in 1991, Community based Primary health care projects started in 52 institutions in 1996. Evaluation was done and this continues.

1. Presently we have Chotanagpur health and development project in Jharkhand and Orissa for last 12 years. The goal is to build the capacity of Partner churches to build a healthy community. About 70% people have adopted preventive measures (Bed net use, Sanitation, &Hygiene practices) to prevent preventable diseases ; malaria patients are referred to PHCs and Mission hospitals ; referral to DOT centers. TB incidence has reduced to 30% ; number of diarrhea and communicable diseases has reduced ; Awareness about HIV/AIDS , Immunization has increased through various programs ; Awareness on ANC/PNC has increased among pregnant women. Trained Dais are available in the community.

About Socio economic Status - there are 300 Self help groups with 4400 members ; 227 have bank account or access to credit facility ; 75% are engaged in economic activities through loans from banks. There are 120 adolescent girls and boys groups sensitized on emerging health issues, life skill education. 10 out of 12 projects have started Community Based Health insurance program 4500 people have registered. 35 insured got medical benefits.

2 Rehabilitation of communities affected by Tsunami in areas were served by CMAI member institutions in Tamil Nadu and Andhra Pradesh. The project gave care to communities specially women and children and elderly population , mobilize them to address specific needs, capacity building, and disaster preparedness .This is at Karakonum, Tirunelvelly, Nagercoil and Pithapuram. Women, adolescent boys, girls and senior citizens groups have been formed.2750 children were given education support. With the result school attendance has increased. 165 low performance children were given additional tuition by volunteers and educational standard has improved. 152 families of orphans are rehabilitated. Technically and financially. SHGs have opened bank accounts. They take benefit of govt schemes as well. They are exposed to other SHGs for learning and are equipped with skill training 2 members from each site are trained in HIV counseling. Participants are trained on disaster preparedness and mitigation Plans to start Community Radio in one project.

3 All AIDS programs of institutions and hospitals are focused on Community based care and support

BUILDING COMMUNITY PARTNERSHIP FOR EMPOWERING PERSONS LIVING WITH STIGMATIZING CONDITIONS

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Community partnership is a process of community organization and development in which a group consisting of certain vulnerable / marginalized sections in a community are the primary stakeholders, working in collaboation with representation of secondary and tertiary stakeholders. The partnership empowers the primary stakeholder group to take collective action to organize themselves, identify needs, issues, mobilize resources and initiate activities to meet these needs leading to strengthening of livelihoods, promoting equity, justice and minimizing discrimination. The cumulative outcome leading to the goal of restoring human rights and dignity of the primary stakeholder group.

The Schieffelin Instiute of Health – Research and Leprosy Centre at Karigiri was started in 1955 to provide comprehensive services to those affected by leprosy and carry out research into the disease. Rehabilitation of persons affected by leprosy and their families was an important component of its services. On most occassions, rehabilitation of this most ostracised group followed the "charity welfare model" or the "medical model".

In 2000, the Department of Community Health embarked on an initiative to facilitate a "Self-Help" and "Rights based" rehabilitation model among those affected by leprosy and living with its consequences. This involved encouraging and facilitating those affected by leprosy and their families (the primary stakeholder group) to organize themselves into cohesive groups, borrowing the concept from the Women's Self Help Group movement that has been active and successful in Tamil Nadu.

Subsequently, based on the commonality of activity limitation and participation restriction with leprosy, it became imperative to extend the membership of the SHGs to other marginalized groups in the community such as, persons with disabilities due to other causes, persons affected by HIV/TB, and later to the poor, destitute and those discriminated due to caste, social class, religion and cultural background. This led to the development of integrated groups. Capacity building, awareness about their rights, improving access to vital information, leadership skills, financial management all helped the primary stakeholders to slowly, but steadily move towards a self-reliance model.

To encourage self-governance of the individual groups, periperal level federations were formed at panchayat level and later these were federated at block level. The Katpadi Integrated Disabilty Society (KIDS) and Inaindha Karangal Voonamutror Kuzukkalin Kootamaippu (IKVKK) are examples

of these block level federations.

The individual SHGs, the panchyat level federations and the block level federations were encouraged and facilitated to develop and form activity or issue based working alliances with a cross-section of partners who shared similar concern, vision and purpose as the primary stakeholder group, identified as the seconday and tertiary stakeholder group. These included the local community leadership, members of the family, players in civil society, the different departments in the Government, schools and educational institutions, financial institutions such as Banks, community based organizations such as youth groups, 'fan clubs', farmers associations, women Self Help Groups, individual activists, industries, religious leaders, lawyers, police, human rights (women/ children/ Dalits and Adivasis) and issue based peoples movements on issues of rights and justice (caste / gender / disability discrimination).

Creating a positive and motivating mission, setting realistic expectations and goals, developing clear action plans, establishing strong management and leadership and clear ground rules and policies are important principles to make the partnership work. The KIDS and IKVKK have worked on some of these issues and much more needs to be done.

Challenges to developing successful partnerships include finding the right balance between the various partners, dealing with disagreements in establishing project goals and implementation strategies, differing opinions and perspectives as well as turf and boundary issues between organizations.

The community based organizations promoted by SIHR & LC are proving to be models of community partnership with scope for replicability in the context of other social and geo-economic commnities who need to be empowered.

COMMUNITY PARTNERSHIP - THE MITRA MODEL

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I had three possible sub-titles for this paper: Community Partnership or Practicing Community Health in Bharat~ or Community Health Nurses - Hum Kissi Se Kum Nahin. I share the experience and perspectives of our team of Community Health Nurses, based on our work in a tribal region of Orissa.

A presentation made on Health Status in our state recently, commented that there are three Indias within our India itself - a Rural India, an Urban India and the tribal India. But for us, we believe that there are two: an India and a Bharat. -An India that is shining in its health care, technological developments, educational advancements etc., etc. There is also a quiet Bharat with its own struggles in terms of health, education, transport, economic and social life; facing major struggles between life and death; Our own brethren who have all the right to enjoy that we enjoy here today - the right to health care, education, economic security and so on. A community with the same enthusiasm, intelligence (sometimes even more than us), commitment and will power just waiting for an opportunity for some one to knock at their doors.

The relationship with our people is the skeleton or the foundation of all we do. Issues and needs are perceived, discussed and acted on. It is difficult now to differentiate between Mitra and the community at many points, as it has often merged. For us, Mitra is a concept, a philosophy, a way of life.

Bissamcuttack is a small town with about 10,000 people, in the hilly district of Rayagada in Orissa. Bissamcuttack block has about 315 villages and 85000 people of whom 62% belong to the adivasi community - the Kondh people, whose language is kuvi, another 16% belong to the dalit community. Most of our Villages are very interior in the hilly terrain with no electricity and roads. This makes healthcare and education inaccessible for the most vulnerable people of our region. Our region is also endemic for malaria with 80% of them being Falciparum malaria.

Christian Hospital, Bissamcuttack is a 200 bedded mission hospital, started in 1954 by a Danish doctor, Lis Madsen. In response to unmet needs. CHB has grown into what it is today. We have about 200 staff, 60,000 outpatients a year, 7000 in-patients, 3000 surgeries, 2000 deliveries and so on. The nearest referral hospital is 200 kms away.

Community Health Department is one of the departments of CHB. "Mitra" is the operational identity of the CH department. "Mitra" means "mend" and is an acronym for "Madsen's institute for tribal and rural advancement".

The Mitra project works with about 11,700 people in 50 predominantly Adivasi villages. These villages fall into 3 geographical clusters and Mitra has 3 cluster teams of 3-4 staff each with a support team at the head quarters. The approach is to be with people and allow the agenda to emerge in the context of this relationship. By the late nineties, we had grown disillusioned with the traditional models

of community health and development with goals and objectives and LFA (Logical Framework Approach) grids We moved to Community Dreaming Sessions and Appreciative Inquiry. What emerged was a four fold Mitra dream - Health for all, education for all, economic security for all, and social empowerment for all.

Each of these has simple components and indicators that we use to measure whether we are getting closer or farther from the dream. In pursuit of the dream, we get into all sorts of activities and initiatives, which phase in and phase out, based on the situation and need. All things do not have to happen in all villages, and nothing must happen unless the village actually decides and asks for it. No demand, No supply.

Mitra residential school Kachapaju: In 1997, a community dreaming session in a hill village called Kachapaju, led to the vision of an adivasi School of our own, where children could grow up in the shoes and milieu of their culture to be equipped to lead their community in these confusing times.

The Mitra Training and Resource Unit : The TRU seeks to widen impact through Training, Consultation and Publications. Over the years we have shared our common expertise in primary health care, Malaria control, HIV & AIDS, Epidemiology, Reproductive health etc. We have been in project evaluations and consultancies for governmental and non governmental sectors.

Community Partnership in this whole process :

1. The face ofmitra is the community itself. More than half of the team is from the tribal community.

   Staffing in Mitra :

   Total no. of full time staff in the department : 27

   No. of staff from tribal community : 13

   No. of tribal staff from project area : 7

   Volunteers (tribal / total)

   Education project (AQTE) : 21/21

   Child care project (MKB) : 9/10

   Health workers at village level : 45/47

   Total representation from tribal community in Mitra team : 88/1 05

   (You have to put your money where your mouth is)

2. AQTE project: Educated youth are selected and trained at MRSK and placed as tuition teachers in villages that have the demand and also the need.

3. MILLA KAHINI BASA (childrens play place) was introduced last year. Children between 3 to 5 years attend these centres. At present 10 villages have these centres. These children are taken care of by an adolescent girl known as Sishu Didi selected by the villagers and trained by us. This was started as a part of a project called Early Child hood Care Nutrition and Education. This whole project is coordinated by community health nurses.

Impact on the community

1. Health :

S. No	Indicators	1995	1998	2002	2007
I.	IMR	201.3	108.6	110	114
2.	PMR	93	43.6	67.4	38.6
3.	TT coverage (%)	42	76.9	89.3	95
4.	% of Home deliveries	96	95	92.5	66.7
5.	% of self conducted deliveries (among the home del)	85.8	86	82.6	80.9
6.	No. of fever deaths	A	60	55	44

2. Education : 2001 2006

Over All literacy rate in project area : 24.2% 33.2%

Female literacy rate : 12.05% 22.4%

MAS Cluster :

	1997	2007
Literacy rate	7.6%	26.7%
Female literacy rate	1.2%	13.8%
School boy : School Girl ratio	75:25	55:45
No. of children enrolled in the AQTE project	756	756

Highlights

We want to conclude by saying that Mitra is an experiment in evolution, with one foot in the grass roots reality of village life, and the other in the science and art of health, education and development. We are constantly brainstorming, dreaming and reflecting; and out of this melting pot come ideas and programmes. Many dreams never translate into actions. Sometimes we might even be doing much less than what we are supposed to be doing. But we keep going with new dreams popping up every now & then, hoping and working towards our dream because as a team we believe

- THE CAUSE IS GREATER THAN OURSELVES.

LEADERSHIP IN EDUCATION

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The constantly changing nature of health and health care necessitates continuous development of educational programmes to prepare Nurse Practioners to practice. Health care reform challenges faculty to prepare students for future roles and to practice in a health care system that is,

* Increasingly client centered
* Community focused
* Technologically advanced.
* Wellness oriented
* Population based

Nursing leaders such as Jean Watson have envisioned a future in which nurses play a predominant role in leading the delivery of health care instead of responding to the demands by others.

As nurses take an active role in developing heath care delivery, nursing education will need to prepare graduates at all levels with appropriate leadership skills. The faculty members have to encourage students to learn not only new knowledge but also enhance the **critical thinking** and **lifelong skills** that will be needed as they meet the challenges of the changing health environment.

Empowerment as a leadership quality : Empowered people are successful in their profession and can provide successful experience for their students.

Empowerment ladder

9	Become empowered	8	Show initiative
7	Resolve conflict	6	Be creative
5	Be a risk taker	4	Value self and others
3	Refuse to be a victim	2	Ability to control life situations
1	Self confidence		

Conclusion

Community Health Nurses at every level must be leaders and change agents to motivate the students to function effectively. Success of leadership depends on the effectiveness of the followers. Characteristics of effective followers (students) are commitment, self-management, integrity and competence.

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LEADERSHIP IN NURSING PRACTICE

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Leadership :

Leadership is often regarded as the important modifier of organization behaviour. It is regarded as primarily personal in character as being founded upon individual preeminence or accomplishment in a particular field of behaviour. The dictionary meaning of the verb ' to lead' shows that the term is used in two different senses: (a) " to excel, to be in advance, to be prominent", and (b) " to guide others, to be head of an organization, to hold " command".

Nursing Practice :

Professional nursing practice involves 'specialized skills essential to the performance of a unique, professional role' (ANA,1975). Although skill changes and evolve with time, a basic value of nursing that has persisted over the years is service to society. The service component of nursing requires integrity and a lifelong commitment. The importance of theory in building a body of nursing knowledge is emphasized by Chinn and Jacobs (1987), who state 'nursing theory ought to guide research and practice, generate new ideas, and differentiate the focus of nursing from other professions'.

Research Knowledge and Evidence based practice, principles of research, clinical judgment and decision making.

Leadership in nursing practice aims to promote the mobility of nurses and develop their potential, enhances their career and share nursing expertise across the world.

The leadership path way develops role of leadership, clinical supervision and mentoring.

Nursing practitioner pathway develops skill in health assessment, diagnostic reasoning and clinical decision making. It involves assessment of advanced clinical skills against recognized standards, concentrating on advance practice and pharmocotherapeutic skills.

1) Characteristics of Leadership
2) Functions of Leadership
3) Why a person assumes Leadership ?
4) Leadership styles
5) Role of a Nursing Leadership

Nursing Theories :

Theories and framework provide direction and guidance for structuring professional nursing practice, education and research. In practice, theories and framework help nurses to describe, explain and predict everyday experiences and they also serve to guide assessment intervention and evaluation of nursing care. Many nurse theorists have made substantial contribution to the development of a body of nursing knowledge. The theories vary in their level of abstraction and their conceptualization of the client, health, illness and nursing.

Trends in Nursing Practice :

1. An intensive effort by the government to meet the health needs of the people, especially those in the rural population.
2. Gradual improved education of people with a growing awareness of health needs.
3. Advanced technology
4. The changing role of woman
5. The continuing growth of populations

Scope of Nursing Practice :

Scope of practice refers to the breadth of opportunity to function. The scope of practice for a nurse includes the type of client, the setting in which the nurse is prepared to practice, and the specific nurse activities the nurse is prepared to perform, the scope of practice for nurses prepared at the different levels of education.

Role of Nurses in Leadership :

Most nurses have grown accustomed to leading and managing their activities as students. Then in professional practice by assuming leadership for the management of their individual work loads and providing nursing care for their patients/clients. Some have leadership for the management process to their practice; others have acquired managerial skills through trial and error. Effective nurses are those who blend the qualities of both leader and manager ; who have followers willing to be influenced by them, and who understand and apply the principles of management to practice.

A nurse performs multiple roles during a day. In nurse case management, for example, the nurse is a manager, planner, organizer, director and controller, co-ordinator, collaborator, expert clinician and communicator with patients and families and all others who influence care. Each member of a role set is influenced by his or her own performance and the actions of others.

Conclusion :

Nursing today provides a widening scope of opportunity for the professional development and services. The trend is to move towards what is practical and meaningful rather than which is traditional or sentimental only. Present trends are moving towards greater opportunities, varieties of services and growing social and professional recognition. It should be exciting and challenging for us to know that we are also become members of this noble profession.

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LEADERSHIP IN PROFESSIONAL DEVELOPMENT

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Some leaders are chosen, some elected and some are born to lead. This is an old adage but too true. Nursing Leadership is essential and as the largest professional group, there is a need for development in equal measure.

Leadership, we are all aware, is an interpersonal process in which one person influences the activities of another person or group of persons towards accomplishing the goal. In essence leadership involves creating a vision and guiding and directing people's belief and behavior towards fulfilling this vision.

In Community Health, all nurses are leaders. For Leadership, certain basic characteristics are a prerequisite. One is to be purposeful, secondly to be able to influence others and third to be able to establish good interpersonal relationships.

NEED FOR PROFESSIONAL DEVELOPMENT :

In the field of Community Health there are several categories of health professionals and if empowerment for optimum health is our goal then development has to reach right down the line to the grass root level and the lowest cadre : the multipurpose health worker the nurse at the Primary Health Centre, and nurses at district level too.

It is well known that a persuasive leadership culture within an organization serves to improve performance. Researches propound that past experience and personality factors predict an individual's motivation to lead. To achieve this mid-level nursing personnel should be given the opportunity to undergo specific leadership training to develop skills and abilities such as effective crisis management, collaborative functioning, analysis of data and forming creative solutions, direct organizations effectively and efficiently, develop knowledge management systems, address planning needs, strengthen public health infrastructure, understand finance and resource development and be a catalyst of change at the organization and societal levels.

All cadres of health professionals need to be provided equal opportunity for professional development in order to be optimally productive.

A Community health nurse is required to be a catalyst for change and as such needs to possess transformation skills also known as "Emotional Intelligence" (Coleman 1998) which is said to have 5 components : self awareness, self regulation, Motivation and Social Skills.

According to Coleman, these components can be learned. Most of our training Programmes cater to "Cognitive" and "Psycho motor" dimensions but do not engage the "Perception or Emotional" dimension. Our training modules need to involve the "emotional intelligence" in equal measure to produce effective community health leaders and nurses.

BARRIERS TO LEADERSHIP IN NURSING

Barriers are many but an innovative leader can always scale them. Culture, "burn out" due to stagnation in their career, limited nursing resources and therefore less opportunity for leadership development are but a few incidents. Being burdened with accountability and responsibility but little authority is a major factor that needs addressal.

CONCLUSION

Taking into consideration the skills required for leadership, it brings home to us the importance of selecting the right person for the job. To work in the community health field one must have a HEART, the passion and motivation to bring about change in "life styles" and thus promoting health of our poorest communities. The Government is working hard to achieve these goals, let us give our all and make the difference.

With the added emotional and intelligence skills that is fine-tuned during developmental training, we can produce the finest Community health nurses who would contribute mightily to the improvement of health care by identifying models and strategies for a World Class Community Health Services.

ABSTRACTS
OF
ORAL PRESENTATIONS

ROLE OF NURSE IN LEPROSY

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Dr. P.S.S. Sundar Rao, Research Consultant, The Leprosy Mission, New Delhi.

Leprosy once affected every continent in the world and has left behind a terrifying image in history and human memory - of mutilation, rejection and exclusion from society. Leprosy is considered to be a special public health problem, due to the permanent disabilities it causes as well as its social consequences such as discrimination and stigma. Currently the vertical leprosy programme has been integrated into the general health care delivery system of the country.

A descriptive explorative study, both qualitative and quantitative in nature was undertaken to study the role of nurse in Leprosy. The objectives of the study were to study the role of nurses in the leprosy eradication programme - case detection, case holding, management of complications, emotional care and support, family involvement in care, community participation, working with Government and NGOs; to study the attitude of nurses towards leprosy; to suggest changes in the nursing curriculum to take up the role.

The study was carried out in SLRTC, Karigiri (Schieffelin Leprosy Research & Training Centre, Karigiri), and the Community Health programmes of Christian Medical College & Hospital (Urban, CONCH, RUHSA & CHAD). The study population consisted of Leprosy patients, nurses, nursing students and the community members.

This presentation touches on the section on the assessment of the nursing students in terms of their knowledge, attitude and practice related to Leprosy. The groups of students who were assessed were IV year B.Sc.Nursing students, III Year B.Sc.Nursing students, and III year Diploma Nursing students. The total number of students studied was 166. The overall findings showed inadequate knowledge in terms of Leprosy and favourable attitude t07ds Leprosy in all the groups of students. Regarding practice, all the categoriesof nursing students were involved in care of Leprosy patients but Diploma nursing students had more experience.

Though the incidence ofleprosy has declined but the deformities and its impact on the patients continue which needs care. The analysis of the curricula related to Leprosy for all categories of students was studied and was found inadequate. It is recommended that the syllabi for the nursing students, both B.Sc. and Diploma need to be strengthened in Leprosy. This will prepare the nurses to take up responsibilities related to other chronic diseases which have similar stigma, eg.AIDS.

EFFECTIVENESS OF A STUCTURED TEACHING PROGRAMME ON KNOWLEDGE ABOUT INFECTION CONTROL AMONG WARD ATTENDANTS OF CMC, LUDHIANA

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Dr. Neelam Thakur, Professor, Christian Medical College, Ludhiana, Punjab

About 10-30% of patients admitted to hospitals and nursing homes in our country acquire nosocomial infection as against an impressive 5% in the West.About 25% of the infections can be prevented by health care workers taking proper precautions when caring for patients.Ward attendants are very much at the front line and play an important role in providing basic patient care and performing disinfectant duties to keep health care settings as clean as they can. The objectives of the study were to assess and compare the mean pre and post test knowledge of Ward Attendants (WAs)and to find out the relationship of effectiveness of structured teaching program (regarding infection control)with selected variables, thereby improving their knowledge and skills, which will help in prevention and control of infection in the hospital. A non equivalent quasi experimental research design was used. Sample of 60 WAs (30 experimental and 30 control group) was selected from all 23 wards and 8 critical care units using purposive sampling technique. Data analysis was done by calculating the "t" value and chi-square test.

The study findings showed that there was no statistical significance in mean pre-test knowledge score among experimental and control group (26.10 & 24.46) whereas post- test knowledge score among experimental and control group (43.1 &25.2) was highly significant at $p<0.001$ level. In the pre-test, majority of WAs of experimental and control group (73.3% and 70%) had average knowledge. In the post-test, majority of ward attendants of experimental group (83.3%) had excellent knowledge whereas in control group, majority of ward attendants (70%)had average knowledge regarding infection control. The study findings proved that the structured teaching programme was found to be effective in increasing the knowledge level of ward attendants about infection control.

EFFECTIVENESS OF A STRUCTURED TEACHING PROGRAMME AMONG MOTHERS ON THE KNOWLEDGE AND PRACTICE OF HOME CARE MANAGEMENT OF CHILDREN WITH TUBERCULOSIS IN DOTS CENTERS OF BANGALORE

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Tuberculosis, a chronic opportunistic communicable infectious disease remains a worldwide public health problem. Every year, 8.8 million people develop TB, accounting for nearly 1/5th of the cases in India. It has been estimated that 10% children affected with TB are infected from adults. DOTS therapy recommended intermittent short-course chemotherapy under direct observation as per RNTCP/IAP policy. Only critically ill children may require hospitalization. Others can be managed at home. So the mothers should be aware of TB management of children with adequate nutrition, immunization, good housing, rest and regular medication.The study involved one group pre-test and post-test, quasi experimental design, with non-probability sampling technique in which purposive sampling method was used. 50 mothers of children with tuberculosis were interviewed by using structured interview schedule. The pre-test was followed by implementation of Structured Teaching Programme (STP) and post-test was conducted after 8 days using same structured interview schedule.

The overall pre-test mean knowledge score was 43.5% followed by post-test score of 82.5%, with mean enhancement of knowledge score of 39%. The overall pre-test mean practice score was 30.8% followed by post-test score of 78.7%, with mean enhancement of practice score of 47.9%. It was observed that the pre-test and post-test mean knowledge and practice score was significant ($P<0.05$).The paired 't' test which was computed between pre and post-test of knowledge and practice scores indicate that there was enhancement in knowledge and practice with value of 26.61 and 25.08 which is higher than the table value of 1.96 and found to be significant at 5% level. The overall finding of the study showed that the Structured Teaching Program was significantly effective in improving the knowledge and practice scores of home care management of children with tuberculosis.

EFFECTIVENESS OF INFORMATION, EDUCATION, COMMUNICATION (IEC) PACKAGE ON KNOWLEDGE AND ATTITUDE ON HIV / AIDS AMONG COLLEGE STUDENTS IN A SELECTED COLLEGE, THIRUTTANI.

Mrs. C.D.Thilagam, Lecturer, Omayal Achi College of Nursing, Chennai, Tamilnadu

Acquired Immuno Deficiency Syndrome (AIDS) is a disease, a medical condition, a health problem, which is primarily relating to people and society. AIDS by its complexity poses a major threat to physical, mental, cultural, social and economic development in the family life of entire population. The adolescent boys and girls may engage themselves in unhealthy sexual practice due to curiosity. Some will not be aware of prevention of AIDS. It emerges as a major health problem. The main objective of the study was to evaluate the effectiveness

of IEC package on knowledge and attitude on HIV/AIDS among college students. A quasi experimental study design was used in this study.100 college students in the age group of 18 to 25 years were included in the study. Simple random sampling technique was used to select the study samples. A structured questionnaire was used to assess the knowledge of college students and Likert scale was used to assess their attitude towards HIV/AIDS.

Data were analysed using descriptive and inferential statistics. The overall mean improvement for knowledge was 4.8 with the 't' value of 18.87 and the overall mean improvement for attitude was 7.1 with 't' value 13.2 which were highly significant at $p<0.001$. The study concluded that there was a significant improvement of knowledge and attitude of college students in post test after administration of IEC package. Thus IEC package was an effective educational tool to improve the knowledge and attitude of college students on HIV/AIDS.

EFFECTIVENESS OF A STRUCTURED TEACHING PROGRAMME ON KNOWLEDGE AND PRACTICE OF NEWLY DIAGNOSED DIABETIC PATIENTS ABOUT SELECTED COMPLICATIONS OF DIABETES MELLITUS

Mrs. Priscilla. K, Lecturer, Matha College of Nursing, Manamadurai, Sivagangai District

The march towards the 21st century started with the slogan "Health for All by 2000 AD". More than 300 million people all over the world are affected with diabetes. The prevalence of diabetes in India is 1-2% and more than 15% of them are found to be in urban areas. The shocking point is that out of these, only 12% are only treated. Srivastava (2001) has said that by 2025, the number of diabetic patients in India is likely to cross 60 million and at present there are only 30 million. A quasi experimental study was carried out in the diabetic clinc of Christian Fellowship Community Health Center(CFCH), Ambilikkai, to assess the knowledge and practice related to prevention of selected complications of diabetes mellitus. A sample of 30 newly diagnosed diabetic patients were included in the study. A structured self administered questionnaire was used as a tool for data collection.

The study found that there was a significant increase in the knowledge and practice of newly diagnosed diabetes patients in the prevention of selected complications after the structured teaching programme. There was a significant association between the knowledge and the age and educational status of diabetic patients. There was also an association found between the practice and the income and the educational status of the patients. There was a positive correlation found between the pretest and posttest knowledge and practice. The study concluded that the nurses have a definite role in educating diabetic patients in the prevention of acute and chronic complications.

PREVALENCE OF OBESITY AND THE EFFECTIVENESS OF STRUCTURED INTERVENTIONAL PROGRAMME ON THE KNOWLEDGE, ATTITUDE AND PRACTICE OF OBESE WOMEN IN RURAL AREAS OF VELLORE DISTRICT

Mrs. M.Baby Saroja, Junior Lecturer, ***Dr. Chellarani Vijayakumar,*** Professor & Head, Community Health Nursing Dept.
Mrs. Rajeswari Siva, Professor, College of Nursing, ***Dr. Vinod Abraham,*** Asso. Professor, Community Medicine, CMC, Vellore

Globally, prevalence of obesity is higher among the women than men population and is on the rise even among rural population for which the national representative data is scarce. Though prevention and management of obesity is easy with simple,concerted efforts, obesity is fast emerging as a global epidemic of the twenty first century. To assess the prevalence of overweight and obesity among rural women of 30-60 years in selected rural areas of Vellore, South India and to determine the effectiveness of structured interventional programme on the knowledge, attitude and practices of obese women in relation to overweight and obesity, a study was undertaken.

A survey on women aged 30-60 years was carried out and 365 women (198 in experimental and 167 in control group) were assessed for their ideal body weight. Hundred samples (50 in experimental and 50 in control group) fulfilling the criteria were selected by Simple Random Method. The data was collected by carrying out physical and nutritional assessment and administering an interview questionnaire for assessing the knowledge, attitude and practices related to obesity. Teaching and demonstration on diet and exercises were carried out to the experimental group. The effectiveness of the interventions was assessed by administering the same questionnaire used in the pretest.

The prevalence of overweight and obesity among rural women aged 30-60 years was found to be higher (42.4%) than the previous studies. Majority of the subjects (96% in experimental and 100% in control group) had poor knowledge, satisfactory attitude, and moderate practices during pretest. There was a significant increase in the overall knowledge, attitude and practices of experimental group ($p<0.000$) comparing to control group in the post-test. The study showed that community health nurses play a major role as facilitators in teaching the people, especially the middle aged women, who are homemakers and are the victims of obesity. This will protect the families, communities and the country at large from the clutches of this global epidemic and reduce the ever-increasing burden of chronic diseases and the health care costs.

VELLORE - WORLD DIABETES RURAL PROJECT

Ruth Ruby Daniel, Diabetes Nurse Educator, ***Jesudoss M, Thomas N, Paul T, Vasan S, Mohan B, Adams V, Ebenezer M, Norman G, Joseph A,*** Department of Endocrinology, Diabetes and Metabolism, Christian Medical College, Vellore.

The aim of the project is to set up Functional Diabetes Clinics and institute preventive strategies in various parts of Rural and Semi-urban India and areas with lower GDP and improve Diabetes awareness amongst the public and health personnel in these areas. The focus of the World Diabetes Foundation (WDF) project was prevention and control of Diabetes Mellitus in rural and semi-urban India through an established network of Hospitals. The objective of the project is to train 100 charitable hospitals to develop Diabetes Clinics, improve inpatient diabetes care, enhance medical, nursing and paramedical practices in diabetes, focus on laboratory and the pharmacy to handle diabetes better. The first step in the project was training of doctors, nurses, laboratory technicians, podiatric technicians and orthopedic cobblers from several Charitable Hospitals and they had training at CMC, Vellore. A total of 17 batches of doctors and nurses were trained.

The clinic is led by a diabetes nurse educator who coordinated the services of a physician, dietician, physiotherapist and ophthalmic technician, and also contributed towards group education and individual education. During their training, the nurses underwent intensive theoretical and practical training in diabetes and also developed a model for the diabetes clinic that they are supposed to set up in their parent hospital. They were taught the basic concepts of diabetic teamwork. They were also taught other skills such as computer usage and networking abilities.

The training programme ensured that the participants were clinically thorough in diabetes mellitus - not just academically but holistically. Diabetes clinics were initiated running in the fashion advised right away- at least once a week, once stable: twice a week. It was further ensured that the laboratory was in good shape and instituted investigations like Lipids, Urine microalbumin/creat ratio, HbA1c. Total Glucometrization and elimination of urine sugars from the menu was done. A spirit of teamwork and egalitarianism was ensured.The diabetic nurse educator had the key responsibility in all the above.

The major achievement till date is that 100 hospitals have been trained and around half of them are functioning. 544 doctors and 132 Diabetes Nurse Educators have been trained and are providing their services to the people with diabetes in their Hospitals and the community. They have also started school awareness programmes, conducted camps and initiated community screening for their people in their vicinities. Trained diabetes nurses have a major role and have been successful for educating patients with diabetes and the metabolic syndrome, improving public health awareness of diabetes and instituting screening programmes. The model of a diabetes clinic initiated and run by nurses is a solution to handling the diabetic pandemic.

RAKSHA CARES YOU

Ms. Jaeny Kemp, Principal, Institute of Nursing, G.K.N.M.Hospital, Coimbatore

Palliative care originated from the Latin word **"Palliare"** meaning 'to cloak'.

Palliative care is any form of medical care or treatment that concentrates on reducing the severity of disease symptoms rather than halting or delaying progression of the disease itself or providing a cure. The objectives of RAKSHA are to provide relief from pain and distressing symptoms, integrates the psychological and spiritual aspects of patient care, to offer a support system to help patients and the family to cope with illness and to use a team approach to address the needs of patients and family. The main goal of RAKSHA is to improve the quality of life for people facing serious complex illness.

Hospice originally meant places of rest for travellers in the 4th century.

It is palliative care provided to those at the end of life. The founder of hospice care is Dame Cicely Saunders. The first was set at United Kingdom known as St.Christopher's Hospice in 1967. 'RAKSHA' the Hospice is a Golden Jubilee Project of Kuppuswamy Naidu Memorial Hospital in the year 2003 March to commemorate its 50 years of services to the community. 'RAKSHA' offers an extension of the services available at the Valavadi Narayanaswamy Cancer Centre at G. K. N. M. Hospital. This facility provides hospice care to cancer patients with terminal illness. 'RAKSHA' is about living - giving the best possible quality of life, comfort, dignity and psychological support in the days that remain. 'RAKSHA' had made a difference in the lives of those needing quality, compassionate, end of life care from inception till date 02-07-08. Nurses play a vital role in providing palliative care.

THE IMAGE OF NURSING AND PERCEPTION OF INDEPENDENT NURSE PRACTICE BY PANCHAYAT LEADERS IN RURAL AREAS OF MADURAI

Mrs. Juliet Sylvia, Professor, ***Ms. Sivalakshmi,*** Asst. Lecturer, Sacred Heart Nursing College, Madurai

Nurses are in the era of accountability and consumer based nursing care provision. Becoming politically active is one of the ways to assume the role of client advocate .The objectives of the study were to assess the image of nursing as expressed by the panchayat leaders and the perception of the leaders on independent nursing practice; to determine the association between the image of nursing among panchayat leaders and the selected demographic variables of the leaders; to determine the association between the perception of the leaders on independent nursing practice and the selected demographic variables and to develop an awareness package on nursing for the panchayat leaders.

A descriptive survey design was used to conduct the study among available panchayat leaders (71). Leaders of both sexes and those who were officiating in rural areas were included in the study. The data collection tool used was an attitude scale on perception towards nursing, media portrayal, Village Health Nurses (VHN) work as well as on the perception on nurses' knowledge, skill for carrying out independent practice.

The study findings showed that 57.75% of subjects had **good image** about nursing. They also suggested that skilled, qualified VHNs to be appointed and they must stay in Government Quarters. Their salary to be improved. They also suggested that Government and the public should stop the Untrained Nurses' Practice. Adequate nurses should be appointed with proper job description. Majority of the leaders (91.55%) supported **independent nursing practice.** Only educational status of leaders had association with perception of leaders.

Panchayat leaders have good image on nursing and support independent nursing practice. Based on the findings, an awareness package on nursing was developed. This awareness will facilitate reformation in policies and in finding a place for nurses to become politically active.

META - ANALYSIS OF STUDIES ON THE ROLE OF FAMILY NURSE PRACTITIONERS IN REACHING THE UNREACHED

Mrs. Rajeswari Siva, Professor, College of Nursing, CMC, Vellore.

Family Nurse Practitioner (FNP) applies advanced practice, nursing knowledge and skills to manage common health problems and illnesses of clients across the life span. The FNP also diagnoses actual or potential health problems, decides on treatment plans jointly with clients, their families and other level of health care personnel, educates and intervenes to promote health, protect against diseases, treat illnesses, manage chronic diseases, limit disabilities and evaluate the effectiveness of the comprehensive nursing interventions. The FNPs are also responsible to improve the health status of communities they serve. Studies have shown that FNPs are able to provide cost effective comprehensive population focused care.

This paper will highlight on the evidence of such through meta-analysis and the systematic review of studies showing the impacts that are made by the FNPs in the care of individuals, families and communities. Such reviews are unbiased and also provide current summary of what we know about the role of FNPs in the health care. These evidences can be translated in the broad areas of care of the communities and populations.

BYSSINOSIS – OCCUPATIONAL DISEASE

Ms. Thangasubulakshmi, M.Sc (N) II Year Student, R.V.S. College of Nursing, Sulur, Coimbatore.

Occupational health is essential. In the past it was customary to think of occupational health. Modern concept of occupational health now embraces all types of employment including mercantile and commercial enterprises, service traders, forestry and agriculture and includes the subjects of industrial hygiene, industrial disease and industrial accident occupational disease are arising out of or in the course of employment. Byssinosis is an occupational lung disease of textile workers. It is due to inhalation of cotton fiber dust over long periods of time. The symptoms of chronic cough, and progressive dyspnoea, ends in chronic bronchitis and emphysema. The incidence of Byssinosis in India is reported to be 7% to 8% from three independent surveys carried out in Mumbai, Ahmedabad and Delhi. The prevalence of Byssinosis is assessed in Kodangipalayam village in Coimbatore using a descriptive study design.

A respiratory symptoms questionnaire was asked to 40 power loom workers. The study findings revealed that 33 workers (83.5%) reported respiratory symptoms related to Byssinosis. The prevalence of Byssinosis symptoms was found to be related to years worked in power loom factory and smoking habits. Males have reported respiratory symptoms rather than the female counterparts. The prevalence of Byssinosis among textile workers is similar to that reported worldwide especially after long exposure to cotton fibers.

PSYCHOSOCIAL STRESS AND COPING BEHAVIOURS AMONG PRISONERS

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A prisoner is an outcast in the society. Once a person is branded as a prisoner, it is the beginning of a life long misery to the person himself and to his family. When he is produced in the Court of Law, the strange and unusual atmosphere of the jail, sudden loss of social contacts, separation from the familial surroundings and loss of independence, uncertainty of future rattle his mental equilibrium. Fear of losing the social status, dread of acquiring a social stigma, as the society looks at these individuals with contempt, disturb the individuals to a great extent. In lieu of that, a comparative study was conducted in Central Jail, Ludhiana, Punjab to assess the psychosocial stress and coping behaviors among male and female prisoners.The objectives of the study were to

compare the mean score of psychosocial stress and coping behaviors among male and female prisoners and to find out the relationship between psychosocial stress and coping behaviors score among male and female prisoners.

Prisoners of 21 – 50 years of age and above were included in the study. Purposive sampling technique was used to collect data from 50 male and 50 female prisoners. A self structured tool of psychosocial stress and modified coping checklist was used. The reliability of the tool was found to be '0.7' (psychosocial stress) and **'0.68'** (coping behaviors) by applying Spearman's Brown Prophecy formula after conducting pilot study. The data analysis was done by calculating the percentage, mean, standard deviation, coefficient of correlation and 't' value.

The data revealed nearly half (56%) of male prisoners and three-fourth of female prisoners (72%) were suffering from moderate psychosocial stress. All the male (100%) and majority of female (94%) prisoners have adaptive coping. Only 6% female prisoners had maladaptive coping. The overall psychosocial stress was lower and coping behaviors were found to be higher among male prisoners than female prisoners.

PREVALENCE OF DEPRESSION AMONG ELDERLY POPULATION IN SELECTED AREA OF TIRUNELVELI DISTRICT, TAMILNADU

Mrs. S.Margret, Principal, Nehru College of Nursing, Vallioor, Tirunelveli

People aged 60 years and older comprise the fastest growing age group in India. In India, 7% of the population is over 60 years of age. General estimate of the prevalence of depression among elderly are 15-20% and 1-16% for major depressive disorders (Mulsant & Ganguli 1999). Diagnosis of depression in elderly is missed 85% of the time. It is found that elders with arthritis and cardiac disease are 18% more likely to experience depression with functional limitation as the strongest factor associated with depression. The ageing process will increase the isolation from family, personal and social relationships. Thus it was felt to identify the prevalence of depression among elderly and the association between selected demographic variables such as education, occupation, locality, family support systems and general health status.

The objectives of the present study were to assess the level of depression among elderly (60 to 75 years) and to correlate the socio demographic variables with the prevalence of depression. A sample of 50 elderly people were selected using purposive sampling technique. The Geriatric Depression scale (GDS) : short form (Lenore & Greenberg 1986) which is specifically designed to assess the depressed mood in older adults was used. The sensitivity and specificity of the GDS was 92% & 89%. The individual scoring of 0-4, 5-8, 9-11, 12-15 indicates normal, mild, moderate & severe depression respectively. Among 50 samples selected 25 were males & 25 were females respectively. The collected data was analyzed using descriptive and inferential statistics.

The results of the study showed that 42% of the elders had moderate level of depression, 38% had mild depression, 10% had severe depression and 10% belonged to normal category. 50% of the elders did not have an occupation which will give them financial stability and so they are expecting financial support only from the children. 10% of elders who had severe depression were only from the rural locality. All the 5 (10%) elders under severe depression category received inadequate support from family. There was significant association between the living locality of elderly population and prevalence of depression and level of family support.

In conclusion, Public Health Nurses and the health care team are responsible for caring of elderly people with depression. Identifying elders with mild, moderate & severe depression along with determining the causes through observations made during home visits; helping the elders and their family members to cope with and support each other in all physical, psychological, social and spiritual aspects can be a challenging and rewarding experience for the nurse. The nurse can be a liaison between the elders and other family members and can also be an advocate in times of need for the elders which will be much appreciated. Thus bridging about changes that can fulfill the needs of the elderly and reducing the incidence of depression in the society.

TAILOR MADE EDUCATION TO THE ELDERLY IN PREVENTION AND MANAGEMENT OF SPECIFIC HEALTH PROBLEMS OF V.O.C COLONY, COIMBATORE

Ms. T. Nirmala, Professor & Vice Principal, PSG College of Nursing, Coimbatore

Can education make a difference in the knowledge level of the elderly in relation to their care? The objectives of the study were to assess specific health problems of elderly based on SPICES instrument; to assess the knowledge of elderly on their specific health problems; to evaluate the effectiveness of health education on the knowledge of the elderly on their specific health problems. The study design selected was one group pretest and posttest design. The sample for study was 49 elderly aged 60 yrs and above.

The results of the study were that among the 49 elderly, 25 were females and 24 were males. Most of the elderly (57%) were economically dependent on their children. Nearly 41% of the elderly had hypertension. Using SPICES instrument, it was found that majority (87%) of the elderly had problems of eating and feeding; 47% of them had sleep disturbances; 29% of them had a fall in the past one year; and 8% had skin problems. Among the 43 elderly who had problems of eating and feeding, 37 had chewing difficulty, 9 had constipation, 4 had indigestion, 3 dry mouth, and 3 had poor appetite. Among the reasons for fall in 14 elderly, 8 of them expressed it as slippery floor, 2 as slippery chappals, 2 as poor lighting, and 2 as giddiness. Performance of paired 't' test showed that education rendered to elderly regarding prevention and management of their specific health problems were effective (t=36.4). It was found that the educational status of the elderly had positive correlation with their knowledge level on the specific health problems.

QUALITY OF LIFE IN THE ELDERLY AND EFFECTIVENESS OF GERIATRIC SOCIAL CLUB

Mrs. Shandrila Immanuel, Reader, ***Dr. Chellarani Vijayakumar,*** Professor & Head, Community Health Nursing Dept., ***Mrs. Rosaline Jayaseelan,*** Professor, College of Nursing, ***Dr. Jayaprakash Muliyil,*** Professor, Community Medicine, CMC, Vellore

The elders are out numbering young people all over the world. Globally, the rate of growth of the ageing population is exceeding the population. It is estimated by the United Nations Department of Economic and Social Affairs Population Division that the number of people over the age of 60 is expected to triple by 2050, making up close to 25% of the expected population. The increase in age brings with it the likelihood of changes in health of all dimensions and this change may threaten the older adults, which in due course may erode their Quality of Life (WHO, 2001) With such changes in dimensions of health, Community Health Nurses could determine new types of interventions that are feasible to the Quality of Life in the elderly. Social support and social activity is essential to all human beings. In addition to making life pleasant and palatable for the elderly, social interaction is essential to survival. Evidence is accumulating that an active social life, help Seniors to lead better and longer lives. The objectives of the study were to assess the existing Quality of Life in the elderly; measure the effect of Geriatric Social Club on the Quality of Life and to recommend a model for community Health Nurses in the care of the elderly.

The aim of this study was to assess the quality of Life of the elderly before and after increased social interaction in the form of Geriatric Social Club as compared to those who did not attend any social club. An experimental research design (Community intervention trial) with an experimental group and control group (20 in the control group and 20 in the experimental group with equal number of males and females in each group) was used The quality of life was measured by using the modified Global Pool of Questions on Quality of Life by WHO. 1996 and a modified questionnaire of Norbeck Scale for social support (Norbeck, 1998) were used. A geriatric social club was started with simple exercises, indoor recreation activities separately for males and females. Data was analyzed by using descriptive statistics of frequency distribution, mean standard deviation and inferential statistics ie Chi square

It was observed that 30% of the subjects in the experimental group who had poor quality of Life before intervention had good quality of life after intervention Similarly, 50% of the subjects who had a fair quality of life

before intervention, showed a good quality of life in physical, social and environmental domains for all subjects. The study found that the Geriatric Social Club helped the elderly to gain an insight into their lives and has paved the way to acquire better coping skills required, for successful ageing. Therefore, Community Health Nurses can assist the elderly in promoting the well being of life through innovative programmes.

ASSESSING FALLS : IDENTIFYING CAUSES OF FALLS AMONG ELDERLY

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Falls are events in which an individual inadvertently comes to rest on a lower than usual level in the absence of an overwhelming force, syncope or stroke. Falls cause substantial morbidity and mortality in older adults including 5.3% of all older adults who are hospitalized. Falls account for significant morbidity and mortality in the elderly. The role of nurse in preventing falls among elderly is significant and it can be reduced by prompt nursing care. In older adults who are at high risk of falls, exercise, safety measures and balance routine must be customized which is the responsibility of the Nurse. So this study was conducted to identify the various causes of falls among elderly which would help in reducing the incidence of falls. The objectives of the study were to determine the causes of falls among the elderly; identify the significance of falls on their activities of daily living; associate the occurrence of falls with selected demographic variables; to formulate a strategy for preventing falls in the elderly among health care providers.

A descriptive study design was selected and the study was conducted in the Geriatric OPD with convenient sampling technique with a size of 160 clients. The data were collected using interview schedule with structured questionnaire method and screening test and examination. The screening test include Gait assessment, time up and go test, MMSE, visual acuity, ADL scoring (Barthal's) and Dix Hallpike Manuover (Vertigo). The data was analysed using inferential statistics and descriptive statistics. (Pearson Chi-Square test, Yates Corrected test and Fisher's Exact test).

The anlaysis revealed that among 160 Geriatric clients, 96 clients were male and 64 were female with history of falls. Assessment of cognitive function using MMSE revealed that moderate cognitive functioning among male showed 84% ($\div 2 = 3.88$, $P=0.05$) and female showed 16% and normal functioning was equal among both gender. Assessment using TUG test showed that 44% were among 60-65 years and 10% were 76-80 years. Age revealed significant P value, ($P= 0.05$, $\div 2 = 5.65$).Among ADL scoring clients with falls among low income group were 94% performed independent ADL, 43% were partially dependent, 9% were totally dependent. Considering DHM, it was positive among 59% of male and 41% of female. Though falls among elderly is due to many non modifiable risk factors, fall risk can be significantly reduced by environmental hazard reduction and essential medical and nursing intervention including health education.

PSYCHOSOCIAL PROFILE OF THE WIVES' OF ALCOHOLICS AND NON-ALCOHOLICS

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A study was undertaken to assess the psychosocial profile of the wives of alcoholics and non-alcoholics in selected deaddiction centres of Chennai, India.A cross-sectional, descriptive design was used. Two selected deaddiction centres – T.T.Ranganathan Clinical Research Foundation, Chennai and psychiatric ward of Sri Ramachandra Hospital were used for the study. Study samples include Wives of the alcoholics who were staying with their husbands during deaddiction treatment and wives of the non-alcoholics who visited the alcoholics admitted for deaddiction treatment in the same deaddiction centres. Convenient sampling technique was used to select 200 wives of the alcoholics and 200 wives of the non-alcoholics. Matching was done on group basis between the wives of the alcoholics and non-alcoholics with respect to three variables: age, education of the wives

and total family income. Standardized instruments were used to measure the psychosocial variables of both groups (General Health Questionnaire 28. David Goldberg, 1972 to measure the psychological distress; World Health Organization Quality of Life Brief questionnaire – 26 items;Social Support Questionnaire, Sarason, et al 1983; Burden Assessment Schedule Thara, et al., 1997; ways of Coping Questionnaire, Folkman & Lazarus, 1988). Psychosocial variables of the wives of alcoholics include psychological distress, quality of life, social support, burden and coping. Psychosocial variables of the wives of alcoholics include psychological distress, quality of life, social support only and did not include burden and coping. Reliability of the instruments was established. Cronbach's alpha coefficient and test retest reliability methods. Interview technique was used to collect the data. The conceptual frame work of this study was based upon Hill's family stress theory.

The study findings reveal that majority (66%) of the wives of alcoholics experienced moderate psychological distress and 29.5% of them experienced severe distress. Majority of the wives of non-alcoholics (99%) experienced only mild distress. In the subscales of psychological distress, 62%, 60.5, 47% and 48.5% of the wives of alcoholics experienced moderate level of somatic symptoms, social dysfunction, anxiety and insomnia, and severe depression respectively. 51% of the wives of alcoholics experienced severe level of anxiety and insomnia. Majority of the wives of non-alcoholics (80.5%P perceived their quality of life as neither poor nor good whereas the majority of the wives of non-alcoholics (95.5% perceived their quality of life as good. The perceived social support and satisfaction was less among the wives of alcoholics than the wives of non-alcoholics. Majority (90%) of the wives of alcoholics experienced severe burden and only 10% experienced mild burden. All eight ways of coping were found to be used by all the wives of alcoholics. Majority of the wives of the alcoholics used positive reappraisal (83.5%), planful problem solving coping (82.5%), escape avoidance (74.5%), accepting responsibility (72%), confrontive coping (68.5%), self controlling (64%), and seeking social support (58.5%) coping moderately to cope up with the stressful situation. 45% of them used distancing coping moderately.

The study also found that there was a highly significant difference between the wives of the alcoholics and non alcoholics in all three compared psychosocial profile. There was a significant inter correlation found in psychosocial variables in both the groups. A comprehensive family assessment done by the nurse with family members in trouble is important to determine their family resources, strengths, coping mechanisms, family values, meanings and perception in order to implement the best family nursing approaches that empower families.

RAMIFICATION OF ADOLESCENT SEXUALITY : PREVAILING ATTITUDE AND CAUSAL FACTORS IN UNWED PREGNANCY

Dr. (Mrs). P. Mangalagowri, Principal in charge, College of Nursing, Madras Medical College, Chennai

Adolescence is generally understood as the period of transition from childhood to adulthood. This is the period during which a person is in second genital stage of psychosexual development. Adolescent population is the largest (i.e.) 22.8% and rapidly expanding segment in our country. Despite stringent controls on the mobility and activity of unmarried adolescents particularly females; opportunities do exist for sexual relationships. The objectives of the study were to explore the factors and also explicit attitudes of the adolescents in relation to their sexual behavior and to allow the parents to unveil their use regarding sexual behavior of their daughters. Exposed Facto/ Correlational research design was used in this study A study was conducted in Government Maternity Hospital and Abortion clinic of Marie Stopes International Non-Government Organization in Chennai. 385 Unwed Pregnant Adolescent Girls were included in the study. Causal factors like family relationships, social relationships, exposure to mass media, and knowledge on female reproductive system, perception on puberty, knowledge on family welfare methods were the study variables. Chi-Square, Kruskal-Wallis, ANOVA and t-tests, Factor, Cluster and Discriminant Analyses were used for analysis of data

Cluster and Discriminant Analysis revealed three different groups of girls in the study. First group of girls belonged to 13 -15 years & 18 years of age, 50% of them were illiterate, and 42% of them were working. Out of them, 64% of the girls were compulsorily involved in the sexual act, whereas the second group girls belonged to 16, 17 &19 years of age and all of them were educated. They expressed that they used to discuss about (70%) sex with friends and 78% of their sexual partners were their classmates. The main reason for sexual act was curiosity (75%) and peer acceptance (75%). Third group is only 25% of the girls. Out of them, 17% were working and their sexual partners were co-workers. All of them said that they knew about sex from Television. The study proved that family relationships, Mass Media, Peer influence, knowledge on sexual and reproductive health has an association with the sexual practices of adolescent girls.

ASSESSMENT OF KNOWLEDGE OF RURAL WOMEN ABOUT MONITORING OF HEALTH STATUS

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An exploratory cross sectional survey was undertaken to assess the knowledge on monitoring of health status among rural women aged 40-60 years in a selected community of Coimbatore District. A sample of 20 women were selected by convenient sampling technique and the data was collected by using a standard questionnaire. Demographic findings revealed that 60% women were in the age group of 40-50 years and 40% in the age group of 50-60% years. All women were married, 40% of them had primary level education, 60% were illiterates, and 50% of them had an income below Rs.1000/ per month and 60% of women were working as coolies.

The study findings revealed that 75% of women had good knowledge about basic information of health, 40% of them had knowledge about Breast Self Examination (BSE), 40% of women had knowledge about monitoring for cervical cancer, 55% of them had knowledge about need for regular monitoring of blood pressure and 50% of them had knowledge about need for monitoring of blood sugar level. 45% of women had knowledge about importance of eye examination to rectify visual problems.

FIRST AID TRAINING FOR THE RURAL YOUTH

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Mrs. Rajeswari Siva, Professor, College of Nursing, CMC, Vellore
Dr. Suresh David, Professor, Accident & Emergency Medicine Dept., CMC, Vellore

Injuries are major neglected public health problem. Accidents are definitely on the increase in India. In India, majority of people in the rural areas has, only 20-30% have health care facilities. The people live in rural areas have no less right to effective high quality care for medical trauma emergencies than urban residences (Lopez –Abuin,2005).First aid care to the injured and medical emergencies can be integral part of rural health care.

A quasi experimental study was done to assess the effectiveness of a structured teaching programme on selected aspects of First Aid and cardio pulmonary resuscitation for the rural youth. The objectives of the study were to assess and compare the knowledge, skill and attitude regarding First Aid to the injured person. The areas selected for the study were rural villages of Vellore District. Seventy two youth were selected from six different villages using convenient sampling technique. Thirty six youth from three different villages were assigned to experimental group and another thirty six from three different villages were assigned to control group. Pretest was conducted using an instrument which had four sections. A structured teaching programme on First Aid was administered to the experimental group. The post test was conducted after one week of Interval. The data was analyzed using descriptive and interferential statistics.

The results of the study revealed that the rural youth of the experimental group and control group had inadequate knowledge, skill regarding the First Aid of injured person. After the administration of the structured teaching programme to the experimental group, the mean score of knowledge and skill significantly increased from 6.94 to 82.21 and 14.99 to 89.08, whereas in the control group there was no significant changes found. The youth of the experimental group developed more knowledge and skill in the cardio pulmonary resuscitation (CPR). The mean score increased from 2 to 84.72 and 6.93 to 91.18 in knowledge and skill in CPR. The training programme on First Aid will be a significant help to the injured victim in times of emergency. This would be a joint venture by the public and medical personnel to combat the ever increasing magnitude of morbidity and mortality caused by accidents.

ASSESSMENT OF ENERGY EXPENDITURE AND BODY COMPOSITION IN DIABETES

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Low birth weight and malnutrition in the intrauterine environment has been established to be an important factor in the development of metabolic syndrome. The aim of the study is to characterize metabolic differences between young Indian men born with low birth weight and normal birth weight with focus on Insulin secretion, Insulin resistance, and body fat distribution and elucidate the pathogenesis of this disorder. If an impaired secretion or action or a defect in energy expenditure is proven in Indians with low birth weight compared to normal birth weight Indians, then it may provide a better understanding of the biology of the metabolic programming in utero.

The objective of the study was to establish Insulin sensitivity by the hyperinsulinemic-euglycemic clamp technique. A cluster random sampling of sixty low birth weight and normal birth weight subjects, with parents alive, healthy males aged 18 to 22 years with fully attained puberty was performed. The subjects were brought from the rural areas for two days to the CMC main hospital endocrinology department for the necessary procedures. The tools used for the study were DEXA scanning to assess the Body composition; Indirect caloriemetry and Actiheart for Energy expenditure; IH Nuclear Magnetic Resonance Spectroscopy to assess skeletal muscle inter and intracellular fat content. The diabetic nurse was involved in the physical examination of the subjects, as well as performing the Hyperinsulinaemic euglycemic clamp combined with an intravenous glucose tolerance test (IV GTT).Blood samples for HDL, LDL, cholesterol, triglycerides, free fatty acids, plasma adiponectin, other markers of insulin resistance were collected. Indirect Caloriemetry for baseline energy expenditure was also performed by the nurse.

This is the first study where indirect and direct determinants of body composition and insulin resistance were performed simultaneously in young healthy adult Asian Indians. In the lean rural South Indian males, insulin resistance indices were significantly related to glucose uptake; fasting insulin levels and the m-value being most tightly associated, even at low body mass indices. Low birth weight was related to a reduction in total energy expenditure in adult males.

SCHOOL TEACHERS AND ROUTINE IMMUNIZATION

Ms. Kirti Rani, Ms. Harmanpreet Kaur, IV Year B Sc Nursing student, ***Ms. Radha Saini,*** Asst. professor, M.M. College of Nursing, Mullana, Haryana

To protect a child from vaccine preventable diseases is a prime responsibility of parents and teachers. Even though Universal Immunization is provided free of charge by Government, still the current level of coverage of "fully-immunized" children under the national immunization program is quite low. But in India, there are only a handful of schools which maintain proper health records of children, or employ a school health nurse,

psychologist/counsellor. A cross sectional study was undertaken to assess the knowledge of school teachers regarding routine immunization in schools of Barara, Dist. Ambala, Haryana. The objectives of the study were to assess the knowledge of school teachers regarding routine immunization and to find out the relationship of knowledge with selected variables.

A descriptive study was undertaken and 200 school teachers were administered pre-tested, self structured questionnaire in March 2008 and convenient sampling was adopted. Data analysis was done by using Z Test and ANOVA.The proportions of teachers who had good knowledge about Routine Immunization (RI) was 17% (34) average 67% (134), poor 16% (32). Mean knowledge score of school teachers' according to different categories of vaccine varied from HIB (3.8%), Vitamin A (4.5%), Birth vaccines and six killer diseases (23.8%) MMR (43%), Tetanus Toxoid (44%), DPT (49.5%), Hepatitis B (71%), Polio (89.17%). Variables like academic qualification, sex, type of school were strongly associated with knowledge of school teachers regarding RI. No significant difference was observed with variables like teaching experience, age, marital status at $p>0.05$ level. School is the second home of a child so school teachers should maintain proper health records of all children and help in motivating and educating parents, guardians about importance of Routine Immunization.

THE ROLE OF TRANSACTIONAL LEADERSHIP IN INFLUENCING A GROUP

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From Mahatma Gandhi to Man Mohan Singh, there are as many leadership styles as there are leaders. Many leadership styles are being followed to understand and influence the group. Transactional leadership is one such fascinating, useful and effective model for managing and inspiring people and it makes the most of all our communications to maintain better interpersonal relationships. Understanding this leadership style and its impact will enable us to become more effective nursing leaders. In this style, the relationship between leader and the group becomes "transactional" - ***I will give you this if you give me that, where the leader controls the rewards, or contingencies.*** In the 1970s, researcher James McGregor Burns wrote a significant book entitled, 'Leadership'. He sought to define the processes or behaviors used by leaders to motivate or influence followers. Burns described different categories, among which, *transactional leadership* seeks to motivate followers by appealing to their own self-interest. The principles of this style are to motivate by the exchange process, the exchange of some reward, such as performance ratings, pay, recognition, and praise. It involves clarifying goals and objectives, communicating to organize tasks and activities with the co-operation of the group members. Transactional leadership is really just a way of managing rather than a true leadership style as the focus is on short-term tasks and it remains a common style in many organizations. The two components of Transactional Leadership-

* Contingent Reward- where the leader provides rewards if, and only if, subordinates perform adequately and/or tries hard enough.
* Management by Exception (MBE) - a conservative approach whereby additional resources are applied in response to any event falling outside of established parameters

However, as the old saying goes, "if the only tool in your workbox is a hammer...you will perceive *every* problem as a nail". A leader should <u>not</u> exclusively or primarily practice transactional leadership behavior to influence others! Some use transactional leadership behavior as a tool to manipulate others for selfish personal gain. It can place too much emphasis on the "bottom line" and by its very nature is short-term oriented with the goal of simply maximizing efficiency and profits. The leader can pressure others to engage in unethical or amoral practices by offering strong rewards or punishments.Transactional leadership seeks to influence others by exchanging work for wages, but it does not build on the worker's need for meaningful work or tap into their creativity. If utilized as the primary behavior by a leader, it can lead to an environment permeated by position, power, perks and politics. Thus a judicial usage of this style is essential for better effect.

QUALITY IMPROVEMENT SERVICES IN NURSING

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Quality is a key dimension of health care. Nurses are the key players in ensuring quality health care. Quality refers to characteristics of and the pursuit of excellence. Quality assurance is an organization's effort to provide services according to accepted proportional standards and in a manner acceptable to the client. Total Quality Management (TQM) is a way to ensure customer satisfaction by involving all employees in quality improvement. Continuous Quality Improvement (CQI) is a process of continuously improving a system. The approach to health care quality improvement is undergoing rapid change. The emphasis has shifted from the assurance of quality to quality assessment and continuous quality improvement. Quality monitoring follows an identifiable process. A quality improvement programme should pervade the entire organization.

The JCAHO has outlined a ten step process of quality assurance for institutions. Standards of quality care evaluates the care provided on the basis of the standards and takes action to bring about change when care does not meet standards.

NUTRITIONAL STATUS OF PRIMARY SCHOOL CHILDREN IN SELECTED RURAL COMMUNITIES OF COIMBATORE

Mrs. Gandhimathi R, Asst.Professor, ***Ms. Nirmala T, Ms. Sathya P, Ms. Deepa N,*** Community Health Nursing Department PSG College of Nursing, Coimbatore, Tamilnadu.

The survey design was used for the study and it was conducted in Panchayat Union Primary Schools. The objectives of the study were to evaluate the degree of malnutrition among school children and to assess the health status of the school children. A total of 558 children studying in the 1st to 5th std. classes were included for the study.

Based on IAP classification, the results of the study showed 181 (31%) children had first degree malnutrition, 107 (18%) had second degree malnutrition and 12(2%) had third degree malnutrition. Considering the BMI index, 5 children came under pre obese classification; one under class I; five under class II and one under class III classification. While considering height, most of the children (344) belonged to normal height range, 234 had mildly impaired height, and 10 had moderately impaired height as per Winslow's classification. The common health problems identified were worm infestation (28%), Dental caries (40%), upper respiratory tract infection (13%) and tonsillitis (4%). Other health problems identified were skin infections, scabies, aneamia, heart problems, etc. As intervention, all children were given deworming medications and dental caries was treated.

The study highlights that inspite of implementation of several special nutrition programmes, nutritional status of the Indian children is very poor and needs attention from the Health care delivery system.

EFFECTIVENESS OF TRAINING MODULE ON KNOWLEDGE OF FIRST AID AMONG THE VILLAGE YOUTH IN SELECTED RURAL COMMUNITY, TAMIL NADU.

Mrs. M. Jayalakshmi, Lecturer, Omayal Achi College of Nursing, Chennai, Tamilnadu

First aid is the very first assistance or treatment given to an injured before the arrival of the qualified health personnel. First aid is provided mainly to save life and prevent permanent disabilities. First aid is provided mainly based on the knowledge of simple human anatomy and physiology. The first aider should update his knowledge and skill to prevent any injury to the victim.Youth think in ways that are more advanced, efficient and they become better able than children to think about what is possible. As youth mature intellectually and undergo cognitive changes, they come to perceive themselves in a sophisticated and differentiated ways. As youth are energetic citizens of India, they have more commitment and responsibilities for building safe India. It will create better awareness and acceptance by the community Hence, they need to be made aware and trained on

first aid at the village level. A quasi experimental study was undertaken among youth of 15 to 25 years of age at Arumbakkam village in Thiruvalluvar District.The objectives of the study was to assess the effectiveness of a training module on knowledge of first aid among the village youth . 40 youth were selected using simple random sampling technique and a structured questionnaire was used to collect data.

The data were analysed using descriptive statistics and inferential statistics.

The study findings revealed that the overall mean improvement for knowledge was 8.05 with the calculated 't' value of 12.75 which was statistically highly significant at $p<0.001$.The study concluded that there was a significant improvement in knowledge on first aid measures among the village youth after administration of the training module. Thus training module was an effective educational tool to improve the knowledge of village youth on first aid measures.

KNOWLEDGE OF ADOLESCENTS REGARDING DRUGS USED FOR COMMON AILMENTS

Ms. Harmanpreet Kaur, Ms. Kirti Rani, IV Year B.Sc Nursing Student, ***Ms. Radha Saini,*** Asst. Professor, M.M.College of Nursing, Mullana, Haryan

Adolescence is an extremely enthusiastic, energetic, joyous and fun – loving period. The power to think intellectually, perform skillfully, handle things meticulously, manage daily affairs tactfully is completely lacking in an adolescent making her a prey to unscrupulous elements of society apart from inflicting pain, turbulence and stress in his life. In India, the prevalence of drug abuse which is generally low in early adolescence aged 12 and 13 rises steeply in the late teenage and is highest during the early twenties. The objectives of the study were to assess the knowledge of adolescents regarding drugs used for common ailments and to find out the relationship between knowledge and selected variables like age, sex, mother's education, father's occupation, type of school and history of self medication.

An exploratory study was undertaken to assess the knowledge of adolescents regarding drugs used for common ailments in Senior Secondary Schools of Barara District, Ambala, Haryana. 500 school children were administered pre-tested, self structured questionnaire in January, 2008 and a convenient sampling was adopted to collect data.Data analysis was done by using Z Test and ANOVA. The results of the study were : Mean knowledge score of adolescents according to different categories of drugs varied from Antispasmodics (6.8%), Antianxiety drugs (8.2%) Antihelminthics (9%), Bronchodilators (11.8%) Antibiotics 22%, Antidiarrhoreal drugs (27.8%) Routine Vaccines (31.4%), Analgesics (32.4%), Antiseptics (36.2%) Antiallergics (45.1%), Muscle relaxants (51.6%). There was no significant difference found with variables like age, sex, mother's education, father's occupation and type of education except that of history of self medication at $p<0.01$. It is concluded that adolescents indulging in self medication had high knowledge scores regarding drugs used for common ailments as compared to those not indulging in self medication.

FACTORS INFLUENCING THE LEARNING OF COMMUNITY HEALTH NURSING - A CROSS SECTIONAL SURVEY

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Education is the foundation of democracy. A student's education depends on his academic performance. The learning ability of the student decides his academic performance. Hence this study was done to identify the various factors that affect learning of community health nursing and associate the factors with selected variables- age, gender, marks obtained, system of education, nationality and religion.

A cross sectional survey with 68 samples from 3rd and 4th year B.Sc. Nursing students was done with the following instruments: Demographic proforma, DREEM (Dundee Ready Education Environment Measure), Rosenberg Self Esteem Tool and Revised Study Process Approach Questionnaire. Results revealed that 77.94%

students felt that the environment was positive to study; the students used both deep and superficial approaches and majority of the students have a high self esteem 77.94%. It has also revealed that in the DREEM score: students perception is positive (46.7%) they are moving in the right direction(80.9%), the academic performance is on the positive side (54.4%), positive attitude on the atmosphere(67.6%)and social self perception was not bad(80.9%). The study tried to find an association between demographic variables and factors affecting learning. This hypothesis was accepted only for esteem and religion (Kruskal Wallis value 0.021, $p<0.05$), gender (M. N Whitney U value 0.017, $p<0.05$). Regression analysis showed that only esteem affects the students learning.

KNOWLEDGE, ATTITUDE AND LEVEL OF SATISFACTION OF HEALTH CARE CONSUMERS IN UTILIZATION OF SERVICES PROVIDED BY OACHC

Ms. D.Celina Paul, Associate Professor, Apollo College of Nursing, Chennai, Tamilnadu

Health care is an expression of concern for fellow human beings and it has become a special commodity. The role of Non Governmental and Voluntary agencies in the health appraisal of the community is highly significant. Quality assurance is getting higher importance in the health care system as there is a heavy investment in the health system on structure and resources. The consumers' perception of quality care has become prime issues as agencies compete for clients. In addition to the demand for quality, the public wants the health care to be delivered at a lower cost, with a greater accessibility, accountability, efficiency and effectiveness. Hence an evaluative study was undertaken to assess the knowledge, attitude and level of satisfaction of health care consumers in utilization of health services rendered by Omayal Achi Community Health Centre(OACHC). The objective of the study was to assess the knowledge, attitude and the level of satisfaction of health care consumers in utilizing OACHC'S services,to correlate the knowledge, attitude and level of satisfaction of health care consumers and to associate the knowledge, attitude and level of satisfaction with demographic variables.

The conceptual framework was based on Rosentoch, Becker and Maximan's Health Belief model which facilitated the investigator to attain the objectives of the study. **Evaluative approach** was used to assess the knowledge, attitude and level of satisfaction of health care consumers in the utilization of services rendered by OACHC. A sample of **100 health care consumers** were selected for the study. The study was conducted in the houses of health care consumers who were residing in 5 selected villages from OACHC's adopted villages. Non probability convenience sampling was used. The data were collected using a **Structured Interview Schedule** to elicit the demographic profile, knowledge, attitude and level of satisfaction of health care consumers. Ethical considerations were maintained throughout the study period.The collected data were analyzed by using both **descriptive and inferential statistics** which included frequency, percentage, mean, standard deviation, correlation co-efficient and Chi square test.

Majority of the health care consumers (87%) were females, and 57% of them were illiterates. The mean score for knowledge was 63.44, for attitude 92.14, and 84.55 for level of satisfaction. There was a positive correlation between knowledge and attitude, attitude and level of satisfaction, knowledge and level of satisfaction at $p < 0.01$ level. The chi-square test showed a significant association between level of knowledge and the demographic variables such as education and reason for visit at $p < 0.05$ and with frequency of visit at $p < 0.001$. The study revealed that there was a statistical significant association between attitude and frequency of visit and reason for visit at $p < 0.05$ and a statistical significance between the level of satisfaction and frequency of visit to the centre at $p < 0.01$.The study findings indicate the collaboration between the different health care delivery systems and involvement of Field Non Governmental Organizations will go a long way in placing the health of the people in their hands.

ROLE OF ANMs IN COMPUTER BASED HMIS IN JHARKHAND

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Ms. Namita Sikdar, MSc Student, P.G. College of Nursing, Bhilai.

It has been seen that ANMs were taking a maximum of 10 minutes to enter one month data of subcentres assigned to them which may be reduced to 5-6 minutes on training and experience. It has been observed that most of the nurses were entering the data with a great enthusiasm. Transfer of health information was faster, accurate and less manipulative than the manual method. Timeliness of data entry was satisfactory. Missing data were seen at many places which were a trend to leave the information as it was not used earlier. This case study has been framed to explore the role of ANMs in computer based HMIS (Health Management Information System) based on implementation HPMIS (Health Programme Management Information System). The project was piloted in Lohardaga district of Jharkhand state in April 2006 and later expanded in 11 districts of Jharkhand State. It was a five year plan to complete capacity building of ANMs for computer learning and making them expert for all data entry at subcentre level through freely available software, DHIS-1 (University of Oslo, Norway).

Quality of data was the biggest concern which was really very bad and was found to improve at subcentre level. Improvement in skills and knowledge of data element may be crucial for them. Some ANMs who were older in age and about to retire were not much interested. ANMs seem enthusiastic about computer based HMIS, and that the computers have a role to play. Computer based HMIS may be worthy to install in the Indian states. Data quality is a major concern to be corrected at subcentre level.

COMMUNITY DEVELOPMENT : GOAT PROJECT

Dr. Jeyaseelan M. Devadason, Dean, Annai JKK Sampoorani Ammal, College of Nursing, Komarapalayam, Namakkal Dt.
Prof. Mr. Murugan

It is believed that the raise in socio economic status enable an individual/family to afford for a better health care. A socio economic project - GOAT was initiated in 2002 and was funded by the Student Nurses Association of Annai JKK Sampoorani Ammal College of Nursing, Komarapalayam. The objectives of GOAT project are to improve the socio economic condition of the weaker section, poorest among the poorer, down trodden, needy, neglected, voiceless and helpless and to evaluate the health status and health behaviour of people in relation to raised economic status among the recipients of goat.People who come under the Below Poverty Line (BPL), aged, widowed, separated, physically handicapped and those who gave consent to replace a goat after one year were included in the project. 40 of them received goats in four villages.

The project evaluation concluded that the goat project revealed that there was an increase in the economic status, amount spent for food, affordability, health status and improvement in their health behaviours. Health is an integral part of community development because standards of health care delivery are closely linked with economic and social structure of the country. Community development programme is cooperative endeavour and self help of people to build a new and prosperous India.

THE NURSES : A SOCIOLOGICAL STUDY OF THEIR PROBLEMS AND JOB SATISFACTION OF NURSES WORKING IN GOVERNMENT HOSPITAL, DURG AND PUBLIC SECTOR HOSPITAL, BHILAI, CHHATTISGARH

Dr. M. E. Patlia, Principal, PG College of Nursing, Bhilai, Chhattisgarh.

Keeping in mind changes relating to nursing profession, there is a need for the different factors affecting nursing profession. The objectives of the study are to identify and compare the socio economic back ground of nurses working in the Government and the Public Sector Hospitals; to understand the various problems faced by the nurses in the family, society and their working environment; to find out the relationship between the socio

economic background of nurses and problems faced by them; to measure the extent of job satisfaction of the nurses The research approach adopted for the study was descriptive in nature. Total sample taken for the study was 495 nurses (228 from Government Hospital, and 267 from Public Sector Hospital).The tool used for data collection was interview schedule containing demographic description, family problems and problems at work place. The sampling technique used by the investigator was convenient sampling. Data collected was analyzed by using descriptive and inferential statistics.

In Public Sector, number of nurses (43.93%) were higher than the percentage of Government Hospital nurses (12%). Majority of (60.6%) nurses expressed that attitude of public towards this profession as very positive. Majority of Government Hospital nurses were satisfied with the nature of the work because of economic security, leave facilities and pensionable job. Majority of Government Hospital nurses felt anxiety and tension in job because of heavy work load, lack of equipments and materialistic facilities. Majority of Public Sector Hospital nurses expressed that they feel tired at work place due to doing house hold work. Majority of Nurses working in public sector Hospital (100%) elderly have more satisfaction due to getting time to spend with family. Educating the public about the importance of nursing services, Work on local initiative that promote healthy work environment for nurses and introduction of welfare schemes need to be worked upon.

ABSTRACTS
OF
POSTER PRESENTATIONS

COMPARISON OF KNOWLEDGE AND ATTITUDE ON OPTIONAL VACCINES AMONG MOTHERS OF UNDERFIVE CHILDREN BETWEEN SELECTED RURAL AND URBAN COMMUNITIES

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The major causes of sickness and death of children in India is mainly because of infectious diseases, many of which are preventable by administering immunization. The vaccination coverage of the eligible population should therefore result in reduction of the disease incidence in the country. So the importance of selected optional vaccines must be repeatedly stressed to parents by health personnel. A delay can lead to undue risks of serious illness. For the achievement of UNIVERSALISATION OF IMMUNITY and to protect the children from infectious disease, to reduce mortality and morbidity, the mothers of under fives need to be aware about the optional vaccines and its importance to reduce the under five mortality rate. The objective of the study were to assess the knowledge and attitude of rural and urban mothers on optional vaccines to compare and co-relate the same and to associate the level of knowledge and attitude of rural and urban mothers with selected demographic variables.

A descriptive research design was used in the study. A knowledge questionnaire and an attitude scale were used to collect data. The vaccines about which the questions asked were Hepatitis A, Hepatitis B, Typhoid, HiB, Chicken pox and Pneumococci. The data were analysed using descriptive and inferential statistics. The results showed that among 60 rural mothers, 46 (76.67%) had inadequate knowledge on optional vaccines and 37 (61.67%) of them exhibited favourable attitude. Among 60 urban mothers, 43 (71.67%) of them exhibited favourable attitude.

There was statistically high significant difference between the knowledge of rural and urban mothers with 't' value 8.05 and statistically moderate significant difference between the knowledge of rural and urban mothers with 't' value 2.425 respectively.The study concluded that the mothers of urban community had moderately adequate knowledge as compared to rural community, whereas both rural and urban mothers had favourable attitude. The investigator having analyzed the data collected has come to the conclusion that the knowledge of mothers both in rural and urban had positive influence on their attitude.

PUBLIC HEALTH IMPORTANCE OF "AVIAN FLU"

Mrs. V.Bharatha Sorubarani, Lecturer, Matha College of Nursing, Manamadurai, Sivagangai District

Avian influenza, more commonly known as Bird flu is a contagious viral infection which can affect all species of birds. Wild water fowls are the primary carriers to cause the infection to domestic poultry. The highly pathogenic Influenza A Virus (H_5N_1) manifested by sore throat, running nose, cough and breathlessness is an emerging avian influenza virus that has been causing global concern as a potential pandemic threat. H_5N_1 strain was first recognized in 1997 in Hong Kong. This was the first evidence for direct transmission from birds to human. During this outbreak, 18 people were affected, with six deaths. After the outbreak, there has been an increasing number of H_5N_1 bird to human transmission leading to clinically severe and fatal human infections. 206 human have died from the H_5N_1 viral infection in twelve countries (WHO,2007). Epidemiologists fear that the virus mutates and it could pass from human to human in future. Thus disease control centers around the world are considering avian flu as their top public health problem. The agent called type A, B & C which has got two distinct surface antigens. (Haemagglutinin – H) which initiate infection and the Neuraminidase (N) antigens which release the virus from infected cell. Respiratory secretion is a source of infection. Infectivity period is 1-2 days before and after the onset of symptoms. It is common for both sexes and all age groups. but elderly and children are more vulnerable.

Epidemic is more common in winter and rainy season and occasionally during summer in India. Broad knowledge about Avian flu helps the community health nurse to apply the preventive strategies at three levels of prevention. At the primary level educate the public on avian flu. avoid contact with poultry (Infected / Dead), cook poultry products well, avoid preparations like half boiled eggs, wash hands with alcohol based hand rub or soap and water, and educate the public about respiratory hygiene. Use appropriate disinfectants for disinfection of materials, toilets and table tops. The preventive measures to be used while caring for a client with avian flu include education

on protecting domestic poultry from contact with the feces of wild birds, Use personal protective equipment (mask, gloves, gown) ,avoiding contact with droppings of infected bird and Respiratory secretions of infected human, prevention of stick /sharp injuries, appropriate environment cleaning and spills management, proper waste management - double bagging system with biohazard- labeling ,immunizations, hospital based and public health surveillance and notification about infected human and infected poultry to the local and international health authority (WHO)

The preventive measures at the secondary level include early recognition, isolation, reporting, maintaining negative pressure (the air conditioning should ensure the direction of the air-flow is from the outside adjacent space eg. the corridor), strict infection control barriers to remain in place for the durations required.respiratory hygiene / cough etiquette, use face mask, use alcohol based hand rub / soap and water to wash hands after contact with respiratory infections, stand (or) sit atleast 1 meter (3ft) from others and administration of antiviral drugs

The nursing curriculum should be designed in such a way to prepare the nurses who are competent enough to

* Identify the high risk group. * Assess the patients infected with Avian flu & Plan and Implement the nursing care. * Evaluate the care provided. * Prepare the health education materials. * Assist the community in developing self care measures, * In-service education to update the knowledge.

APPLICATION OF EPIDEMIOLOGY IN COMMUNITY ORIENTED NURSING

Ms. Kalpana B, Lecturer, Sree Narayana College of Nursing, Nellore, Andhrapradesh.

Epidemiology is the study of factors affecting the health and illness of populations, and serves as the foundation and logic of interventions made in the interest of public health and preventive medicine. It is considered a cornerstone methodology of public health research, and is highly regarded in evidence-based medicine for identifying risk factors for disease and determining optimal treatment approaches to clinical practice.

Primary care epidemiology is the application of epidemiological principles and methods; the study of heath problems encountered in primary care including their etiology, prevention and diagnosis and with a view to improving their management.

The nursing implications include

Education

- Improving understanding of patterns and clinical significance of common symptoms and conditions seen in primary care
- Providing information that can optimize the efficient use of primary care services.

Practice

- Providing a frame work for the design and targeting of feasible and acceptable.

Research

- Epidemiology is needed to describe the incidence, prevalence, severity and the natural history (duration, remission and resources) of symptoms, and signs, and of defined illness occurring in the community. How these problems vary among different groups within the community (e.g. by age, gender, socioeconomic status, ethnicity, place of residence) and how these problems cluster or relate to each other.

Epidemiology is not new but its scope and potential is wide and increasing, requiring expanded investment of personnel and resources in community settings. Primary care epidemiology can make a distinct contribution to our understanding of health and illness and health care utilization.

AVIAN FLU

Mrs. Tamilselvi.P, Mrs. Revathy.D, Ms. Kiruthika Devi.D, Nursing Tutors Institute of Nursing, G.K.N.M.Hospital, Coimbatore, Tamilnadu

Avian Influenza is a Flu infection in birds. It is otherwise known as Bird Flu which is caused by H5N1 Virus. In human, flu viruses shuffle and rearrange their genetic material. In India till date, Avian Flu cases were reported thrice so far. First in February 2006 in Navapur District of Maharashtra, then in July 2007 in Imphala District of Manipur and in January 2008 in Dakshin and Dinajpur Districts of West Bengal. Farmers and people working with poultry, people who eat raw or undercooked poultry meat are at risk of getting the infection. The common signs and symptoms include cough (dry or productive), sore throat, fever more than100.4^{0}F, diarrhea, running nose, head ache, muscle aches, mild conjunctivitis and acute respiratory distress.

The common diagnostic tests to rule out the infection include real time -PCR Primer and Probe Test, chest X-Ray, nasopharyngeal culture and complete blood count.Anti-viral agents such as Oseltamivir and Zanamivir are used in the management of infection. In severe respiratory distress ventilator support is needed. The common complications of avian flu are viral pneumonia and Acute Respiratory Distress Syndrome. The preventive measures are avoiding visits to live- bird markets in areas of Avian Flu outbreaks by the travelers, proper hand washing, steer clear of raw eggs and by washing thoroughly and cooking properly the poultry. The community health nurse has an important role in the prevention of Avian Flu in the community.

COMBINED CARE CLINIC (CCC) SERVICES IN COLLEGE OF NURSING, CMC, VELLORE A MODEL TO REDUCE PERINATAL MORTALITY

Mrs. Vathsala Sadan, Professor, ***Mrs. Greeda Alexander,*** Professor, ***Miss Irene Dorathy***, Tutor,
Dr. Chellarani Vijayakumar, Mrs. Rosaline Jayakaran, Mrs. Rajeshwari Siva, Mrs. Baby Saroja,
Mr. Devan Prabhudoss, Miss Mary Jancy, Miss Angeline, Miss Priya Ranjani, College of Nursing, CMC, Vellore

In any community, mothers and children constitute a priority group, also a vulnerable or special risk group. The problems affecting the health of pregnant women are multifactorial. The complications associated with pregnancy are not always predictable. Therefore, to improve the health status of the pregnant women and to provide the basic maternity services to all the antenatal mothers in the CONCH area is a vital and expanded role of the each Community Health Nurse. The College of Nursing Community Health (CONCH) programme started in 1987, serves a rural population of 67,883 in 20 villages in the Arcot and Vellore Blocks of Vellore District. In 1990, the Combined Care Clinic (CCC) was started with the help of OG Department of CMC.

The following are the objectives of the CCC programme

1. To reduce the Perinatal Mortality Rate of the area served by CONCH programme from 90/1000 live births to less than 30/1000 live births
2. To maintain the Maternal Mortality Rate to 0/1000 live births
3. To improve antenatal care services to 100%
4. To facilitate the highest quality care to the pregnant mothers in the tertiary hospital according to their socio economic status.
5. To facilitate quality neonatal care in the tertiary level

High risk approach is being used by the community health nurses at the village level and are referred to CCC services. The high high risk mothers are advised for hospital delivery. Pregnant mothers who delivered in other hospitals or homes come with the problems during intranatal, post natal period are also referred to CCC by the community health nurses. Home follow ups are made for both the post natal mother and the new born baby. The CCC programme made an impact in the life of the pregnant mothers and the new born babies in the rural area and we were able to bring down the Perinatal Mortality Rate from 90/1000 live births(1987) to 28.63/1000 livebirths(2007) and to maintain the Maternal Mortality Rate 0/1000 live births.

EFFECTIVENESS OF DIETARY COUNSELLING REGARDING ANEMIA AMONG ADOLESCENT GIRLS

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The World Health organization lists iron deficiency as one of the ' Top Ten Risk factors contributing to Death'. The prevalence of anemia was 4-5 billion people, 66-80% of the world's population; Adolescence is an opportune time for interventions to address anemia. In addition to growth needs, girls need to improve iron status before pregnancy.Counseling is one of the most effective interventions. A large number of diseases could be prevented with little or no medical intervention if people were adequately informed about them and if they were encouraged to take necessary precautions in time.The objective of the study were to determine the knowledge regarding iron rich diet among adolescent girls before and after dietary counseling and to assess the effectiveness of dietary counseling regarding anemia before and after dietary counseling.

Rosenstoch's Health Belief Model was used for the study.Pre experimental one group pretest-post test design was used. A sample of 40 adolescent girls were included in the study using nonprobability convenient sampling. The study showed that 17.5 % adolescent girls had inadequate knowledge and 72.5% of adolescent girls had moderately adequate knowledge regarding diet in anemia during pre test. During post test 77.0% of adolescent girls had adequate knowledge, 23.0 % adolescent girls had moderately adequate knowledge. Paired t test showed that the mean post test knowledge score (2.78 %) was higher than the mean pre test knowledge score (1.93%) and the t' value was significant at 0.05 level. There was no significant association between knowledge and demographic variables.Imparting knowledge on prevention of anemia through dietary counseling helps nurses to emphasis on iron rich diet, and also helps to understand economic ways to obtain iron rich diet by acquired knowledge on cooking demonstrations and kitchen garden. This study recommends to carry out further research using time series design and to observe dietary practices.

ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH FOR GIRLS

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The structure and functions of female reproductive system includes external reproductive organs and internal reproductive organs. Conception takes place when a sperm and egg joins and fertilization occurs. In the menstrual cycle there are four stages and it includes regenerative, proliferative, secretary and menstruation stages. Menstrual hygiene includes taking bath regularly, washing perineum after using toilet, applying clean sanitary pads. The menstrual and gynecological problems consists of dysmenorrhea, menorrhea, epimenorrhoea, metrorrhogea, and oligomenorrhgea. The recommended adolescent nutrition includes per day intake of 2200 calories, 45 to 60 grams of protein, 1200 mg of calcium per day and 15 mg of iron. Body mass index can be assessed by weight (kg/height m^2)

Responsible sexual behaviors which need to be taught to adolescent are avoiding homosexual activity, abstinence from sexual contact before marriage, say "NO" to peer pressure, avoid extra marital sexual relationship. Teenage births create health risks for the baby like low birth weight and compilations such as bleeding in the brain and respiratory distress syndrome. Sexually Transmitted Infection (STI) is a group of diseases which spread from an infected person through sexual contact. It includes gonorrhea, syphilis and HIV/ AIDS. AIDS is caused by Human Immuno Deficiency Virus (HIV). The common mental health problems in adolescents are depression, anxiety and substance abuse. Promoting mental health by positive, carrying and supportive relationship between adolescents.is important.Ensuring that the adolescent live free from excessive stress, violence, abuse etc.and to have good living conditions.

CULTURE AND TEEN CARE

Mrs. Latha, Lecturer Rani Meyyammai College of Nursing Annamalai University, Chidambaram

The age between 12-19 and 15-19 among the female and male respectively can be treated as adolescene (WHO/UNFPA/UNCCEF).It is the crucial stage, opinions are formed and values are required which last for good in their lives. Risk taking behaviours of adolescents such as intentional or unintentional injuries, tobacco use, alcohol and other drug use, sexual behaviour, unhealthy dietary behaviours and physical inactivity are considered to be causing morbidity and mortality among them (Khan,1997). Culturally competent programme is developed to provide culturally competent services for the adolescents. In the rapidly changing health care environment the nurses role continues to be central to provide safe and quality health care.

Certain prerequisites have to be accounted, in terms of viewing the health, relationship of cultural presumptions of health care system and the client, respecting the knowledge, beliefs and practice, interaction, time spent in the community, learning of cultural attitudes about health and illness, and the level of 'acculturation' for providing such services.

Nurses can use the Nursing process to facilitate the development of such programs.

1. Assessment (Cultural appraisals).
2. Planning (use of the information obtained during assessment).
3. Implementation (to determine how individuals in the cultural act on their beliefs).
4. Evaluation (Examine the criteria identified by the cultural group's prospective participants).

EVE'S ROAD TO HEALTH

Mrs. Jaeny Kemp, Principal, Institute of Nursing, G.K.N.M Hospital, Coimbatore

The health concerns of girls originate much before her birth and the life – cycle approach is the need of the hour .The government policies need to ensure that women's health is a public health priority throughout her life from birth till old age. For women, the right to health is very important for a variety of reasons both choice and access are often denied to them. Traditionally women bear primary responsibility for the well being of their families. They were denied access to resources – education, health care services, job training and access and freedom to use family planning programme.

Women's health differs from men because of biological differences and also as a result of gender differentials in exposure to risk factors. Women derive their status primarily from their childbearing role and their value is often measured by the number of sons they have. They depend on male children for social status and economic security and are often reluctant to use contraception prior to having a son. Family planning practice rises significantly among women who have two or more sons. The cultural practices of women eating last in the family takes a toll on her health.

The status of women's health is largely reflected by the indicators like female mortality and morbidity, disease burden, reproductive health and encompassing reproductive behaviour, contraception, abortion, maternal mortality and morbidity, gynecological morbidity and infertility, nutrition, work environment and health covering aspects like poor sanitation, air pollution, degradation of natural resources, sexual harassment and health problems related to nature of women's productive work, and violence against women and its consequences for the health care system of women. The economic growth of our country depends on the health of women from womb to tomb.

EMPOWERMENT OF WOMEN IN HEALTH

Mrs. Jaeny Kemp, Principal, Institute of Nursing, G. K. N. M. Hospital, Coimbatore

Empowerment is the process which enables one to gain power, authority and influence over others, institutions or society.

Characteristics

* Having decision-making power of one's own.
* Having access to information and resources for taking proper decision.
* Having a range of options from which you can make choices (not just yes/no, either /or).
* Ability to exercise assertiveness in collective decision making.
* Having positive thinking on the ability to make change.
* Ability to learn skills for improving one's personal or group power.
* Ability to change others' perceptions by democratic means.
* Involving in the growth process and changes that is never ending and self-initiated.
* Increasing one's positive self-image and overcoming stigma.

The development of women has always been the central focus of the developmental planning since independence. The shifts in policy approaches in the last 50 years from the concept of welfare in the 70's to development in the 80's and now to empowerment in the 90's are fully reckoned with. The most significant turn around strategy was in mid 80's with the Seventh Plan, which started and moved towards equality and empowerment. The Eighth Plan marked a further shift towards the empowerment of women emphasizing women as equal partners in the development process. The Govt. of India has ushered Empowerment Year to focus our vision in the new century of a nation where women are equal partners. However, health empowerment still remains a distinctive problem for Indian women as exemplified by the health statistics.

Empowerment of Women needs to be finalized to bridge the gap between equal de-jure status and unequal de-facto position of women in the country. The women's empowerment the health sector is now redefined and approach in health has moved beyond describing men and women's health in isolation and brings into analysis of how gender differences, exposure to risk, access to benefits of technology and health care, rights & responsibilities and the control exercised by people over their lives have been altered by globalization. The issue of sex ratio, son preferences, early marriage, poor health and nutrition, maternal mortality etc has been reviewed in the transitional Indian society.

QUALITY IMPROVEMENT SERVICES IN WOMEN'S HEALTH

Ms. K. Thamaraiselvi, Professor, Matha College of Nursing, Manamadurai, Sivagangai District

We have achieved so much in terms of health, while compared to pre-independent India, but still we have to go a long way to achieve the quality of women's health especially in some states of Northern India. Illiteracy, ill health and poverty are the root causes for all problems and vice versa. Male dominated Indian society refuses to give equal status to women and they suffer with violence, discrimination, ill treatment and issues related to reproductive health. To improve the women's health status, Woman's Health Initiative 2005 has taken steps in developing countries like India & Malaysia.

The model adopted to this article is an integrative model developed by Luffrey and Kulbok (1999) which comprises two dimensions :

1. Client system

It refers to women as an individual, part of a family, aggregate and community. She is an active partner with the nurse in every step of her health care to achieve maximal health potential.

2. ***Focus of care***

Health promotion, disease prevention and illness care are the focus here to provide quality improvement services in women's health. The nurses work with the community leaders and lay people to plan programmes to promote optimal health of the women by her active involvement.

Implications

Nursing practice

* First of all the nurse should teach the public about the importance of women in a family and regard her as a partner not as a subordinate and add that she is a change agent in promoting health of her family.
* The nurse should spend more time with the mother and communicate the health information.
* Use interdisciplinary and innovative approach
* Collaborate and co-ordinate with women's welfare services and create sustainable programs
* Involve women while taking decision regarding health.

Nursing education

* The nursing curriculum should be planned in such a way that the women's health should be taken care from womb & tomb.
* The curriculum should emphasize evidence based nursing care focused on population, based on current trends and issues in relation to women's health.
* Nurses should be taught to raise their voice for women in the media.

Nursing research

* Participate in all the meetings, conference workshops etc. on women's health.
* Encourage colleagues and women to participate and do simple research activities.
* The nurse must do time too time research and improve quality and quantity of women's health based on up to date knowledge.

INNOVATIONS IN TEACHING AND LEARNING IN COMMUNITY HEALTH NURSING

Mr. G.Srinivasan, Vice Principal, Narayana Collge of Nursing, Nellore, Andhrapradesh

The demand for community health nursing practice is increasing as various global factors influence the daily lives and health of individuals. We are an inclusive world class enterprise of discovery that prepares innovative, evidenced based health care providers, education leaders and researchers to optimize health in culturally diverse global community. The overall aim of teaching and learning in community health nursing should be to prepare competent specialist group of community nurses, to facilitate the provision of high quality, evidence based, and cost effective health care services. Problem Based Learning (PBL) is used in teaching and the students are directed to identify possible solutions and potential outcomes which are realistic.

The teaching should be focused on four domains which include searching for health needs, simulation of awareness of health needs, influence on policies affecting health and facilitatation of health enhancing activities. Documentation is very important in the assessment of quality of teaching and learning. Peer reviewed publications of research, accreditation, successful applications of technology in teaching and learning, positive peer assessments, grants to support teaching and learning, and outcome studies to evaluate educational programs are some of the essentials in teaching and learning in community health nursing.

INNOVATIONS IN TEACHING AND LEARNING IN COMMUNITY HEALTH NURSING

Ms. Geetha, Ms.Jothy, II Year M.Sc., Nursing Students, Apollo College of Nursing, Chennai, Tamilnadu

Today's Educators are faced with interesting and baffling challenges. One should admire the health care educators who teach fellow staff, allied health professionals and nursing students, because they must instruct students in the complexities of critical thinking."Technology" is also a factor in the present day situation. Many teachers are teaching both in virtual and real world. The high involvement factor helps to overcome the gaps in age, experience and culture. They are many new methods of teaching – Dancing Techniques, Games, Portfolio, Simulation, Mime, Tableau. Many different strategies would be appropriate for any student group and class content. Through out the course, it is important to vary the strategies.

The modified PRECEED – PROCEED model was originally conceived and presented by Green, Kreuter, Deeds. Et. Al. (1980) as a model to guide a process of teaching. The "Preceed" stands for "Predisposing reinforcing and enabling cause in educational diagnosis and evaluation" "Proceed" acronym stands for policy, regulatory and organization constructs in education and environmental development. This model has nine phases.

INNOVATIONS AND TECHNOLOGY IN COMMUNITY HEALTH NURSING EDUCATION

Ms. M.A.Sahbanathul Missiriya, Asst.Professor, Saveetha College of Nursing, Chennai.

It is our experience that explosion of knowledge not only affects the human life but also impacts education. There is a requirement of simplifying all the innovations and technology to make it understandable, adaptable and affordable to the society.

Innovation refers to both radical and incremental changes in thinking, in things, in processes and in services. Educational technology is a complex integrated process involving people, procedures and ideas. The purposes of innovation in education is to make education more productive and individual based; to give instruction more scientific base. There are various projected and non projected aids used in educational technology. There is an increasing use of computers in education.

Some of the educational innovations are Dial access, Educational television, video, interactive video, teleconferencing , E-mail, computer, artificial intelligence, computer assisted instruction, local area net work, compact disk(read only memory) and digital video interactive.

MULTIMEDIA TEACHING AND LEARNING IN COMMUNITY HEALTH NURSING

Mrs. Nisha Clement, Vice Principal, VSS College of Nursing, Bangalore, Karnataka

Educational technology involves the application of recent discoveries of science and technology to the process of teaching and learning. Technological opportunities are currently presented to educators that combine a number of strategies and methodologies that have never before been available to faculty. As nursing moves into 21st century, there are many instructional options potentially available for use in the classroom, also for patient teaching and in tertiary care centers. Educators recognize that there is increased student retention of content when more than one physiological sense is stimulated. In the early years, audio and motion films were used as a first step to stimulate multiple senses in learners. In 1990's, we find that the possibilities have increased considerably. Multimedia technology in basic terms, refers to the use of more than a single medium. Multimedia involves computer projected video, audio, motion imaging, slides, online access of material or discussion etc.

The term multimedia was widely used to define a collection of different media. With the arrival of personal computers possessing audio-video capacity multimedia has a power to store elements taken from different sources on a single storage medium, a compact disc. A multimedia package which needed a collection of materials is now delivered via a single channel - computer. Multimedia teaching provides students with opportunities to represent and

express their prior knowledge. It also allows students to function as designer, using tools for analyzing the world accessing and interpreting information, organizing their personal knowledge, and representing what they know to other multimedia applications, engage students and provide valuable learning opportunities. It also empowers students to create and design rather than absorbing representations created by others.

Self-learning occurs, in case the student and the teacher are separated both in space and time, and as such, interaction between them is not possible. Self-learning take place with the help of printed books, programmed instructions, educational cassettes, videos and films and (mechanical, electronic or computerized) teaching machines. Socratic teaching methods are characterized by interactions between the teacher and the taught. The student teacher interactions are clarification, discussion, individual assignment and group assignment. The advancement in electronic media forces the teachers to change their traditional methods of teaching. The role of teacher is more than that of facilitator, guide and resource seeker. It is also essential that the teacher educator should recognize these new roles and skills and start training teachers to develop and welcome a partnership with the computer.

ROLE OF NURSE EDUCATOR IN PREPARING FAMILY NURSE PRACTITIONERS

Mrs. G.Thilagavathy, Principal, Rass Academy of College of Nursing, Poovanthi, Sivagangai District

Family Nurse Practitioners are professionals who provide comprehensive health care to Individuals across the lifespan in primary care health service settings. Graduates of this program will provide the diagnosis and management of common acute and chronic health problems of individuals from infancy through adulthood. Emphasis is placed on an evidence based family centered approach to health promotion and illness intervention.

The following professional values serve as a framework for nurse educators :

* Caring - empathy, compassion and sensitivity in the delivery of relevant nursing and health care services
* Altruism - the concern for the welfare and cultural beliefs of others, patient advocacy and mentorship of colleagues;
* Autonomy - professional decision-making and collaboration with patients in planning their nursing and health care;
* Human dignity - respect for sensitivity toward the worth and uniqueness of individuals and populations;
* Integrity - adherence to the nursing code of ethics and recognized standards of professional practice.
* Social justice - fair, non - discriminatory and equal access to nursing and health care resources; and
* Life-long learning - commitment to maintaining professional competency throughout the professional nursing career, (Mayhew & Ford, 1974)

The goals of Family Nurse Practitioner's programme include :

* Compliment existing knowledge and experience in nursing practice
* Develop mastery of knowledge and skills related to primary health care
* Be critically reflective practitioners and role models as they develop their family nurse practitioner's role
* Develop a focused vision of high quality, evidence based nursing practice for health promotion, prevention of diseases and management
* Provide professional leadership
* Effective intersectoral coordination to ensure high quality, comprehensive, holistic primary health care
* Promote the delivery and management of evidence based and community focused care

The major role of nurse educator is vital in practitioner's role As a knowledgeable practitioner , the nurse educator demonstrates behaviour and the abilities to perform ongoing clinical assessment.

Nurse implications

- Nurse educators should take initiative to include standards and criteria for Practitioners' role,
- formulate sets of outcome criteria of a quality review system in the nursing curriculum.,
- Plan for orientation program and in-service program related to quality care
- Provide facilities to maintain quality care.

Nurse educators are responsible for designing, implementing, evaluating and Revising academic and continuing education programs for nurses. These include formal academic programs that lead to a degree or certificate, or more informed continuing education programs designed to meet individual learning needs.

COMPETENCIES OF FAMILY NURSE PRACTITIONER

Mr. Kandasamy M, Assoc.Professor & Head, Department of Community Health Nursing, Sri Gokulam College of Nursing,Salem, Tamilnadu.

Nurse Practitioner is a nurse with professional training and additional knowledge, skills and attitude for assuming responsibilities for providing first level assessment and treatment to family members. The population in family care practice includes newborns, infants, children, adolescents, adults, pregnant and post partum women, and older adults. The focus of care is the family unit as well as individuals belonging to the family. The Family Nurse practitioner is a specialist in Family nursing, in the contexts of community, with broad knowledge and experience with people of all ages. Upon graduation or entry into practice, the Family Nurse practitioner demonstrates competencies in the following:

1. Health Promotion, Health protection, Disease prevention and treatment.
   a. Assessment of Health Status.
   b. Diagnosis of Health Status.
   c. Plan for Care and implementation of treatment.
2. Nurse Practitioner - Patient relationship.
3. Teaching - Coaching function.
4. Professional role.
5. Managing and negotiating Health Care Delivery systems.
6. Monitoring and ensuring the quality of Health Care Practices.
7. Cultural competencies.

Nurse practitioner is a specialist in primary health care where scope of practice includes providing comprehensive health services, encompassing health promotion, prevention of diseases and injuries, treatment, rehabilitation and services to clients of all ages in communities.

OCCUPATIONAL HEALTH NURSING

Mr. Kandasamy M, Assoc.Professor & Head, Department of Community Health Nursing, Sri Gokulam College of Nursing, Salem, Tamilnadu.

Occupational Health Nursing is the application of Nursing principles to conserve the health of workers in all organizations. It emphasizes prevention, recognition and treatment of illness and injury and requires special skills and knowledge in the fields health education and counseling, environmental health, rehabilitation and human relations. The scope of occupational health nursing includes collecting health history, assessment, surveillance, primary care, counseling, health promotion/protection, administration and management, quality assurance, research and community collaboration. The philosophy of Occupational health nursing practice and service should empha-

sis the conviction that the health and safety of the worker and the work force as the concern of the occupational health nurse. It should reflect statements of beliefs and values about promotion and protection of health, workers rights working environment, employer and employees' responsibilities, benefits of occupational health service and the competencies of staff.

The Occupational Health nurse has various functions like assessment, prevention, provision of treatment, health promotion, provision of nursing care, counseling, environmental sanitation, safety education, administrative functions, maintenance of records and evaluation of health programmes. The major four roles she plays are professional role, environmental role, managerial role, and educational role. The advanced practice roles in occupational health nursing are clinician/practitioner, administrator, researcher and consultant.

PREVALENCE OF MALNUTRITION AMONG UNDER SIX CHILDREN

Mr. Abhishek Suroy, Ms. Harmanpreet Kaur, Ms. Kirti Rani, IV Year BSc Nursing Student,
Ms. Radha Saini, Asst. Professor, MM College of Nursing, MM University, Mullana, Dist.Ambala, Haryana.

In South Asian region, nearly 5 million children are dying every year, and up to 3 million of these deaths are directly or indirectly associated with malnutrition. In spite of a large number of national programmes related to nutrition such as ICDS, mid-day meal, etc., about 6600 under-five children die everyday, accounting to 46% child deaths due to protein energy malnutrition (PEM). A cross-sectional study was carried out to find the prevalence of malnutrition in under six children of selected primary schools of Barara, Dist.Ambala, Haryana. The objectives of the study were to find out the prevalence of malnutrition in primary school children under 6 years of age and to find out the relationship between the degree of malnutrition and the selected variables like sex, age, father's occupation,mother's education and the type of school. A convenient sample of 500 school children were included in the study. Heights and weights of all children were assessed by using standard anthropometric methods. Data was analyzed using mean and mean percentage.

The study findings showed that 33.6% (168) of school children were malnourished .Girls and boys accounted to 16.4% (82), 17.2%(86) of total population.First degree malnutrition was prevalent in 11%(55)girls and 12.4%(62)boys and 2nd degree was prevalent in 5.4%(27)girls and 4.8%(24)boys. In the age group of 2-4years, as many as 13.9%(22)boys and 13.6%(23)girls had 1st degree malnutrition whereas 2nd degree malnutrition was 8.9%(9) among boys and 1.04% (2) among girls. In the age group of 4-6 years 1st degree malnutrition was prevalent in as many as 23.8 %(40) boys and 20.83% (35) girls whereas 2nd degree malnutrition was prevalent in 8.9 %(15) boys and 13.09 %(22) girls. Maximum number of malnourished children (both sexes)had father's occupation as daily wagers/DPL'S followed by servicemen and shopkeepers/small businessmen. Maximum number of malnourished children (both sexes) had mothers who were illiterates followed by 10th pass mothers,10+2pass mothers and Graduate mothers. Maximum number of malnourished children belonged to private schools as compared to Government schools.

A COMPARITIVE SURVEY TO ASSESS THE PROVISION AND UTILISATION OF WATER SUPPLY AND SANITATION FACILITIES IN AN URBAN AND RURAL COMMUNITY, COIMBATORE

Mrs. Saramma Samuel, Professor & Vice Principal, RVS College of Nursing, Sulur, Coimbatore

The Millennium Development Goals (MDG) adopted in the year 2000 aims to reduce global poverty, improve the lives of the poor and increase the pace of development. The target of MDG is to halve the proportion of people without access to safe drinking water and sanitation facilities by 2015. This study was conducted to survey the existing situation in terms of water supply and sanitation in the community. A descriptive survey method was used to collect data from the Urban and Rural areas of Coimbatore. A sample of 60 participants was selected for the study using convenient sampling technique

The study results were analysed in terms of water facilities, availability of toilets/latrines and disposal of waste 90% of the sample in the Rural areas and 63% in the Urban areas did not have drinking water connection

inside the house. 70% in the rural areas had drinking water available in the common water tap daily/alternate days, whereas 100% in the urban area had drinking water available once in 7-10 days. 57% in the rural and 80% in the urban areas did not have latrines inside their houses. 90% in the rural and 3% in the urban areas practiced open field defecation. 87% in the urban areas used common latrines for defecation.

80% in the subjects of urban areas and 100% in the rural areas threw the garbage on the road side. 53% in the rural areas and 93% in the urban areas reported that there were no common dust bins available in the community.

QUALITY IMPROVEMENT SERVICES IN OCCUPATIONAL HEALTH

Ms. V. Hemalatha, Ms. Priya, Ms. Parvathavarthini, I Year M.Sc. Nursing Students, Apollo College of Nursing, Chennai, Tamilnadu

Occupational Health defined in 1950 by the first session of the Joint International Labour Organization/WHO Committee aims at promotion and maintenance of the highest degree of physical, mental and social wellbeing of workers in all occupation. The objectives of providing quality services are maintenance and promotion of workers' health and working capacity, the improvement of the working environment and work to become conducive to safety and health, development of work organization and working culture in a direction which supports health and safety at work and in doing so also promotes a positive social climate and smooth operation which may enhance productivity of a undertaking concerned.

The activities of the occupational health nurse are focused towards providing expert assistance and consultation to the public like evaluating a workplace, safety and health program, particularly the design of occupational health care system, reviewing, screening and surveillance processes for a specific hazard, record keeping have special knowledge of workplace hazards and the relationship to workers' health, understanding industrial hygiene principles, and have knowledge of toxicology and epidemiology as related to workers and the work site. The Luxemburg declaration a modern corporate strategy, aims to prevent ill health at work (including work related diseases, accidents, injuries occupational diseases and stress) and enhancing health promoting potential and wellbeing in the work.

COMMUNITY HEALTH NURSE MAKES A DIFFERENCE IN HEALTH CARE

Mr. I. Clement, Principal, VSS. College of Nursing, Bangalore, Karnataka

Health of the community denotes the health of the society and nation. People's health is one of the important parameters of community health practice. Community health nurse works at the preventive, therapeutic, restorative and rehabilitative level. Community health nurse is a key person of health team, participates actively in all the National Health Programmes and activities. Community health nurse is responsible for providing all opportunities and facilities to provide total care to the entire community. Community health practice is concerned with the application of community health concepts for providing and promoting health for all people at large. Community health practice implies providing need based systematically planned comprehensive health care services. The emphasis is on primary level prevention and uses of community approach. Community health nurse provides and promotes need-based comprehensive nursing service of individuals and families. The services are rendered to promote and protect the health of family members, to regain and maintain their health, to prevent them from acquiring diseases.

The community health nurse achieves objectives by giving continuous health teaching, guidance and support, counseling, personal and therapeutic care and health checkup. Community health nurse provides supportive services to physician in making diagnosis and carrying out medical treatment. The Community health nurse while providing health care services to families, helps them improve their environment conditions, modify their life style affecting their health, strengthen their resources, capacities and abilities; make psychosocial adjustments. She directly and actively participates in health promotion and prevention of diseases, assists in early diagnosis and treatment of disease and also in prevention and limitation of disabilities.

The community health nurse conducts health education on various aspects of healthful living, prevention and control of various local diseases. She helps in early detection of cases by making observation, enquiry in the clinic, in homes and schools

She also participates in epidemiologic investigations of various diseases, planning and implementing of prevention and control programme for various diseases. The Community health nurse directs, guides and supervises auxiliary nurse midwives / multi purpose health workers in delivering health care services to assigned community. The community health nurse co-ordinates the work of male and female health workers and other personnel. She is also a member of health team plans, organizes educational programme for the community and organizes health camps.

COMMUNITY BASED PALLIATIVE CARE

Mrs. Shakila Murali, Tutor, Dept.of Radiotherapy, Christian Medical College, Vellore, Tamilnadu.

It is estimated that one million new cases of cancer occur every year in India with over 80% presenting at stage III and IV. Experience from cancer centres confirms that two third of patients with cancer are incurable at present and need palliative care. Palliative care in India is in a relatively early stage of development and consequently faces numerous problems. The extent of problems relating to lack of care is not well described for cancer or non malignant diseases.

A system based home care service has proved cost effective and has empowered families to care for patients at home. The community approach is the only realistic model for two third of the world's terminally ill. Meaningful palliative care requires a combination of socio-economic, cultural and medical solutions. All three must be addressed. Today there is an over emphasis on the medical approach and only by empowering the community, this can be balanced. The desired approach will be one that provides valuable support and care and addresses the key problems of the terminally ill in a community by a multi disciplinary team.This model aims to reflect community involvement in the services provided by the Palliative care unit.

IDENTIFICATION OF HIGH RISK ADULTS FOR HYPERTENSION AND DIABETES IN A RURAL COMMUNITY

Mrs. Maheswari, II Year M.Sc Nursing Student, Sacred Heart Nursing College, Madurai, Tamilnadu

The prevalence of hypertension in rural area of India is 157.44/1000 population, for diabetes it is over 20 million,. If self identification is done earlier we could prevent the higher morbidity and mortality rate. A descriptive study was undertaken in a rural area of Madurai District. The objective of the study was to identify the risk for hypertension and diabetes mellitus. . 135 normal adults from 31 to 60 years were included in the study. The adults were selected to be included in the study by using purposive sampling technique. Of the samples selected, 63 were males and 72 were females. A self administered questionnaire was used to collect the data. Descriptive statistics was used to analyse the data

The study findings revealed that most of the sample had (86%) elementary education & (68%) were heavy workers. 60% of males and 54% of females were in moderate risk group. 29.5% males and 42% of females were in low risk group, and none in high risk group. The study concluded with the following recommendations :

1 Low-risk for Diabetes Mellitus (DM) and Hypertension(HT) : Need to take preventive measures to avoid developing DM and HT. Monitor BP and RBS.

2 Moderate risk for DM and HT : Need to change lifestyle to treat HT, DM. Monitor BP and RBS at yearly intervals.

3 High-risk for DM and HT : Need to change lifestyle, try to reduce weight, Exercise regularly, limit alcohol intake Practice Yoga or Meditation. Monitor BP and RBS every six months.

The study also found that self administered tool helps in detecting risk groups.

ASSESSMENT OF KNOWLEDGE AND PREVALENCE OF SELECTED RISK FACTORS OF HYPERTENSION AMONG ADULTS OF PANDESWARAM VILLAGE, THIRUVALLUR DISTRICT.

Mr. V. Chithravel, Lecturer, Omayal Achi College of Nursing, Chennai, Tamilnadu

Hypertension is the commonest cardiovascular disorder posing a major public health challenge to population in socio economic and epidemiological transition. It is one of the leading cause of death and disability among the adults globally. The increasing incidence of hypertension will exert a devastating price on the physical and economic health of the global community. Hypertension results from many risk factors which can be modified through community based life style interventions. The risk factors of hypertension include age, gender, race, genetic predisposition, obesity, lack of physical activity, diet, smoking, alcohol consumption and stress. The prevalence of risk factors of hypertension is increasing in developing countries like India. The earlier prevention starts the more likely it is to be effective. The awareness about the risk factors of hypertension will motivate lifestyle modifications so that the prevalence of cardio vascular morbidity can be prevented.

A descriptive coorelational research design was used to assess the knowledge and prevalence of risk factors of hypertension among adults in a rural area of Thiruvalluvar District. 60 adults in the age group of 25 to 55years were included in the study using nonprobability convenient sampling method. A structured questionnaire was used to assess the knowledge and a rating scale was used to assess their stress level. Descriptive and inferential statistics were used for data analysis.

The study findings revealed that the gender and type of family had a significant association with knowledge on hypertension. The gender and family history of hypertension also had a significant association with prevalence of selected risk factors of hypertension. It was found that there was a negative correlation between knowledge and prevalence of selected risk factors of hypertension.

The study concluded that knowledge on hypertension determines the prevalence of risk factors of hypertension along with family history, type of family and sex of the individual.

ANALYSIS OF RISK FACTORS IN SEIZURE DISORDERS

Ms. Deepa Raman, Lecturer, Dr. G. Sakunthala College of Nursing, Tiruchy, Tamilnadu

Epilepsy is a serious disorder having important medical, social and psychological consequences. The majority of patients presenting for treatment are under 5 years of age. The objective of the study is to find out the exposure rate of seizure disorders and measure the strength of the association between risk factors and seizure disorders in case and control groups of children. A case control design was used to analyse the risk factors of seizure disorders. Among the case group, 30 under five children with seizure disorders and among the control group, 60 under five children without seizure disorders were randomly selected. The risk assessment tool was used to analyse the risk factors regarding seizure disorders.

The relative risk (RR) and odds ratio (OR) were analyzed under maternal related factors such as history of abnormal delivery (RR=6.3; OR=11), prolonged labour (RR=9.0; OR=10.5), preeclampsia (RR=6.5; OR=9), family history of seizure disorders (RR=6.7; OR=7.3), and child related factors such as birth asphyxia (RR=14; OR=38), mental retardation (RR=8.6; OR=21, cerebral palsy (RR=8.0; OR=12.7), childhood accident (RR=8.5;OR=11.8), history of febrile convulsion (RR=6.0; OR=9.5). There was a significant association between seizure disorders and demographic variables of children such as age, education of the mother, and locality at 0.05 level. The additional risk factors identified by the investigator were brain hemorrhage, agenesis of corpus collosum, premature rupture of membrane and polyhydramnios. High exposure rates and strength of association was observed between maternal related factors such as history of abnormal delivery, prolonged labour, pre eclampsia, family history of seizure disorders and child related factors such as birth asphyxia, mental retardation, cerebral palsy, childhood accident, and history of febrile convulsion.

JUNK FOOD AND OBESITY

Ms. L. Santhi Derma, II Year M.Sc (N) Student College of Nursing, Madras Medical College, Chennai, Tamilnadu

Junk foods refer to fast food which are easy to make and easy to consumer. They have more of fats causing ill effects on the health of the consumers. The taste is the most attractive feature in a junk food. The contents are rich in salt (sodium), sugar and fats which provide high calories, yet useless in nutritive value. Junk foods are popular because of their simplicity in preparation and their pleasant taste. Burger, Pizza, fried fish, chips, pasta, crisps and sweets have all at some time classified as junk foods. The adverse effect of junk foods on adolescents leads to obesity.

A descriptive study was undertaken to determine the awareness and practices of junk food consumption and its effects on obese and non obese adolescents in selected schools of Kanyakumari District. The objectives of the study were to find out the prevalence of obesity among adolescents and to assess their practices related to junk food consumption. 200 adolescents (100 obese and 100 non obese) adolescents in the age group of 13 to 17 years were selected using convenient random sampling technique. A structured interview schedule was used for data collection. The data will be analysed and the results will be discussed.

NON COMMUNICABLE DISEASES

Ms. Mathew Sony, Ms. Sujatha, & Ms. Tamizhkodi, II Year M.Sc Nursing Students,
Apollo College of Nursing, Chennai, Tamilnadu

Noncommunicable diseases are assuming increasing importance among the adult population in both developed and developing countries. They include cardiovascular, renal, cancer and mental diseases. Cardiovascular diseases and cancer are the leading causes of death in developed countries and account for 70 to 75% of total deaths. Currently, the prevalence of these diseases show an upward trend in India too. The impact of non communicable diseases on lives of people is serious when measured in terms loss of life, disablement, family hardship, poverty and economic loss to the country.

Only tertiary prevention seemed possible in earlier years to delay the development of further disabilities. But now, with the identification of risk factors and health promotional activities we are aiming to reduce the incidence and prevalence rates of these diseases. The approach used by the community health nurses should be holistic in handling the complicated medical cases. The role of a community health nurse is extensive in this area.

OBESITY

Miss Jhansi Rani. K, Faculty,Institute of Nursing, G.K.N.M.Hospital, Coimbatore

In the past days, society view obesity as a symbol indicating strength and wealth. But now-a-days obesity is identified as a rising threat to collective well-being. Obesity is emerging as a health epidemic around the world Obesity is a disease in which excess body fat has accumulated to such an extent that health may be negatively affected. The common risk factors are age, family history, current cigarette smoking, sedentary life style and increased waist to hip ratio. The common predisposing factors for obesity are genetics, culture, physical inactivity, emotional or psychological factors, gender, age, high fat or calorie diet, and medical problems.

The major health risks related to obesity are shorter life expectancy, premature death and other risks like diabetes, joint problems, high blood pressure, heart diseases, gall bladder diseases, some types of cancer, digestive disorders, breathing difficulties, psychological problems, infertility, urinary incontinence, and pickwickian syndrome. The risks related to psychological and social well being are negative self image and social isolation

The non surgical treatment for obesity are dieting, exercise, medications and behaviour modifications. Batriatric surgery can be done as surgical treatment

The other restrictive procedures include adjustable gastric banding which involves banding of the upper part of the stomach and vertical banded gastroplasty which involves stapling near the oesophagus to produce a small stomach pouch.

The malabsorptive procedure – Billiopancreatic diversion which involves removing three fourth of the stomach and reduces the food intake and also involves dividing the small intestine. Gastric Bypass Roux-en-y can be performed in which stapling of the stomach is done to produce a small pouch.

COMPARISON OF PROFICIENCY OF METERED DOSE INHALER (MDI) USE WITH ASTHMA CONTROL

Ms. Vedha Radha, Respiratory Nurse Educator, ***Dr. D.J.Christopher,*** Professor & Head, Department of Pulmonary Medicine, ***Ms. Beulah Premkumar,*** Professor & Head, Medical Surgical Nursing Speciality, College of Nursing, CMC, Vellore

Asthma is a chronic disease seen world wide and the morbidity is high, despite the advances in the treatment. Among the reasons for poor asthma control, the most important is the poor compliance with treatment and improper use of inhalation devices.

A study was undertaken to assess the inhalation techniques of asthmatics using pressurized Metered Dose Inhaler (pMDI) with holding chamber and correlate it with Asthma control. Patients who were 15 years or older with physician diagnosed asthma attending the Pulmonary Medicine OPD at Christian Medical College, Vellore were eligible for inclusion if they were on Preventor medication using a pMDI, with a holding chamber. Relevant clinical data was obtained and Asthma Control Test (ACT) was administered. Peak Expiratory Flow Rate was measured and the inhalation technique was assessed.

A total of 202 subjects were studied, in whom 56% could be classified as "misusers" and among them 3.96% also had poor co-ordination. ACT Scores were lower among misusers than in good users (ACT; 15.6 versus 20.8; $p<0.0001$) and among the misusers it was lower in poor coordinators than good coordinators (ACT:13.25 versus 15.0 $p<0.001$). There were more; misusers among those who had only school education when compared to those with graduate and higher education (MDI Score; 10.5 versus 15. Misuse of pressurized Metered Dose Inhaler, is frequent in Indian Subjects and is associated with poor asthma control. This study highlights the importance of providing appropriate education and periodic evaluation of the pMDI technique. Bad technique was more common in those who had less than college education and in the elderly.

ABC OF SMOKING CESSATION

Mrs. Beulah Premkumar, Professor, Medical-Surgical Speciality, Pulmonary Medicine Department, Christian Medical College, Vellore.

India is the largest producer of tobacco in the world. Tobacco worth Rs.24,000 crores is sold annually and the Government has to spend Rs.27,000 crores annually on free health services to treat the harm caused by it. Smoking is consumed in different forms in India as beedies, cigarettes, chewing tobacco, snuff, cheroots, chuttas, dumpties, chillums and hookahs

Smoking cessation interventions are widely underused in India specially in primary and secondary care levels of health care services. Smoking causes much harm not only to the physical health but also the family members specially the children, neighbors, friends, co-workers and co-travelers and almost the entire society wherever he smokes. The children are the most vulnerable group who suffer due to passive smoking with increasing incidence of cough, bronchitis, ear infections and pneumonia.

The five "A" S approach summarises the role of health professionals in managing smoking. **A**sk, **A**ssess, **A**dvise, **A**ssist, and **A**rrange are the antismoking interventions in routine care. Smoking cessation interventions are simple, cheap, and effective but not yet widely part of our routine care. Clinicians and public health personnel must develop and use routine and systematic approaches to inquire about and recording the smoking health status of patients. Cessation interventions need to be audited and monitored.

QUALITY IMPROVEMENT SERVICES IN GERIATRIC CARE

Mrs.Annie Frieda. A,Mrs.Lalithamani. D & Ms.Regupriya. M, Faculty, Institute of Nursing, G.K.N.M.Hospital, Coimbatore

The term Geriatrics was proposed in 1909 by Dr.Ignatz LeoNascher. Gero informatics is the development, application and study of health informatics in geriatrics. Geriatric Nursing is the key specialty in the field of nursing . Geriatric nursing provides care for the elderly population through health promotion and prevention of disability and disease. It focus is more on the treatment of chronic condition. It provides support and education for families of elderly patients. Communication with family members provides valuable information about the patient. Geriatric nursing is to provide higher quality care and limit the hospital admission by providing early prevention problems common to elderly, such as Dehydration, Undernourishment, Sleep disorders, Falls, Delirium, and Skin breakdown.

Geriatric assessment and comprehensive evaluation reveals the numerous problems of the aged. It helps to evaluate the older persons ability to maintain good health , improve their overall quality of life, reduced the need for hospitalization and enable them to live independently for as long as possible. An assessment includes the following steps.

* An examination of older persons current status in terms of their physical, mental and psychological health.
* An identification of current problems or anticipated future problems.
* The development of a comprehensive care plan which addresses all problems identified, specific interventions or actions required.
* Management of a successful linkage between these resources and older person and the family members.
* Ongoing monitoring to identify newer problems and the needed modification in care plan
* Geriatric assessment can be done in hospital, nursing home, out patient, physician office and in patient's home
* Advanced geriatric care management involves all indepth assessment, developing a care plan arranging services and follow up in monitoring care.

Health Care is a continuum and rather than breaking the patients journey into arbitrary steps (under 65 , above 65, acute care, sub acute care etc) a patient 's continuity of care should be maximized whenever possible. Advocacy, innovation and teaching of health care for elderly people need enthusiastic supporters. Our challenge is to continue to incorporate specialized geriatric training in everyday practice.

QUALITY IMPROVEMENT SERVICES – ELDERLY CARE

Ms. K.Rajarajeswari, I Year M.Sc Nursing Student, Apollo College of Nursing, Chennai

It is necessary that elders will have to age gracefully and peacefully. The ageing process is associated with many factors. Like health status, economic independence and their role expectation in family and status accorded in the family. There are ways and means for the senior citizens to lead a healthy life physically, mentally, socially and spiritually Life satisfaction in aged people is achieved by focusing on physical well being, involvement in social activities, claiming need based maintenance from their children, provision of return of property bestowed on children for maintenance of parents and spiritual growth.

Nurses can demonstrate creativity and leadership as they break from traditional roles and settings and develop new models of practice for helping elders to die with comfort, peace and dignity. The role of a geriatric nurse should be directed towards increasing the span of healthy life. A holistic model for gerontological care is

developed and followed. Watson's philosophy and science on caring theory can be used to explain the concept-quality improvement services in elderly care with the ten important factors:

* Formation of humanistic system of values
* Instillation of faith/hope
* Cultivation of sensitivity to oneself and to others
* Development of helping trust relationship
* Promotion and acceptance of positive and negative feelings
* Systematic use of scientific problem solving method for decision making
* Promotion of interpersonal teaching and learning
* Provision of supportive, protective mental, physical, socio-cultural and spiritual environment
* Asssistance and gratification of human needs
* Allowance for existential phenomenological forces

Thus, this theory can be utilized in caring for the elderly, thereby, the quality improvement is assured because Evidence Based Practice yields protection.

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